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Multidisciplinary Care Planning using a Developmental Work Research Approach

Pugh, Julian

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Multidisciplinary Care Planning using a Developmental Work Research Approach

Julian Pugh

A thesis submitted for the degree of Doctor of Health

University of Bath

Department for Health

September 2011

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Authorship Declaration

I, Julian Pugh, confirm that this thesis and the work presented in it are my own achievement.

1. Where I have consulted the published work of others this is always clearly attributed.
2. Where I have quoted from the work of others the source is always given. With the exception of such quotations this dissertation is entirely my own work.
3. I have acknowledged all main sources of help.
4. If my research follows on from previous work or is part of a larger collaborative research project I have made clear exactly what was done by others and what I have contributed myself.
5. I have read and understand the penalties associated with plagiarism.

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Abstract

This research addressed change management and learning in a multidisciplinary addictions chronic care environment in order to prepare for shared care planning within an electronic health record. It used a Developmental Work Research approach and was able to use insights from Bernstein's theory of knowledge structures, Bakhtin's work on social language and a Critical Realism approach to address weaknesses in the base Activity Theory approach. In these ways problems concerning fragmented, demarcated silo working across clinical and non-clinical addictions services could be examined. The objective of the study was to identify tensions and contradictions in working environments and to engage multidisciplinary workers in a collaborative change laboratory environment via the use of co-configuration and expansive learning. The working group examined past and current practice and were able to formulate new forms of practice, based on the use of a shared care plan tool, to address identified problems and national policy aims. It was able to use the aforementioned theoretical insights to illuminate the multiple utility of the shared care plan tool as a pedagogic device. This enabled the production of new practice possibilities, paradigms and planning to be undertaken, and the consideration of these within the context of 'real time' multidisciplinary activity within a forthcoming national IT system. This research has explored, identified and formulated new practice to improve multidisciplinary working between clinical and non-clinical workers across diverse sectors. This will have significant health and cost benefit gains for clients, workers and organisations as well as translating policy aims into effective practice. The next stage will be to manage the roll-out of the forthcoming IT system using the theoretical and methodological developments crafted in this research endeavour.

List of Abbreviations

AT	Activity Theory
ANT	Actor Network Theory
BOSS	Build on Social Supports
CHAT	Cultural Historical Activity Theory
CJS	Criminal Justice System
CL	Change Laboratory
DCRAGA	Department of Community, Rural and Gaeltacht Affairs
DWR	Developmental Work Research
EBP	Evidence-Based Practice
EHR	Electronic Health Record
EPS	Electronic Patient System
HL	Hybrid Laboratory
HSE	Health Service Executive
HSETP	Health Service Executive Transformation Programme
ICP	Integrated Care Pathway
LIW	Learning in Work Project
M&E	Monitoring and Evaluation
MMT	Methadone Maintenance Treatment
NDS	National Drugs Strategy
NPM	New Public Management
ORF	Official Recontextualising Field
OMD	Office of the Minister for Drugs
PCT	Primary Care Team
PI	Performance Indicator
PRF	Pedagogic Recontextualising Field
RCT	Randomised Controlled Trial
SCP	Shared Care Plan
SMART	Specific, Measurable, Achievable, Relevant, Time-related
TCD	Trinity College Dublin
TLDTFP	Tallaght Local Drug Task Force and Dodder Partnership

Glossary

Activity Theory

Activity theory was developed by Vygotsky and his collaborators and grew from initial concerns about the mediated relationship between humans engaging with their environment by using tools, signs and cultural factors. Activity theory provides object orientated analysis of human activity by using artefacts.

Cultural Historical Activity Theory

CHAT was a development of activity theory by Engeström to examine activity systems at a collective level in terms of five principles. He introduced factors such as tensions and contradictions as drivers for change in developing new practice.

Co-configuration

"Co-configuration describes the dynamic networks between service users, products and providers that characterise emerging forms of interagency dialogue. Learning in and for co-configuration goes beyond conventional team-working and, instead, encourages knotworking as the principle of rapidly changing, partially improvised, distributed forms of collaboration" (Warmington et al., 2004).

Developmental Work Research (DWR)

DWR is a methodology or research intervention based on a number of group work sessions known as the change laboratory in which workers are facilitated to examine identified tensions in terms of their activity systems. The use of an expansive learning model in tandem with mediating artefacts, signs and tools are used in object orientated activity to drive change and seek a new form of productive practice.

Change laboratory

This provides an environment in which a group of participants can redesign their work and organisational activity by utilising and developing new models of practice with the use of tools and practices with the facilitation of a researcher. The change laboratory provides for a comparison between past, current and future practice. Accordingly, an appreciation of processes, motives, relationships and resistances, as well as periods of change or lack of movement can be comprehended (Engeström, 1999a).

D-analysis

D-analysis is based upon the identification and analysis and tracing of sequences of communicative action which marks significant features of thinking and change within DWR which may pass through some or all stages. It examines "what-it- is- to- learn" via five stages.

Expansive learning

The process of expansive learning (Engeström, 1987) assists the transformation process in moving from one state of social practice and organisational structure to another and as such reflects the movement from idea generation to translating that idea through innovation and a process of learning and diffusion of knowledge. This involves the expansion of the object that is being worked upon, which in this case is the construction of a shared object in relation to a client care trajectory.

Boundary crossing

"The concept of 'boundary-crossing' is integral to analyses of the unstable, heterogeneous, multi-voiced character of interagency working. In the 'divided terrains' in which interagency provision is located expansive learning becomes a mechanism to enable renegotiation and reorganisation of collaborative relations and practices between and within the activity systems. Boundary-crossing implies a different notion of 'expertise' from the vertical image suggested by standard competence-orientated conceptions of learning. Activity theory derived analyses of interagency working suggest that learning in practice is dependent on *horizontal* movements across contexts and across boundaries of professional expertise" (Warmington et al., 2004).

Zone of proximal development (ZPD)

The term was developed by Vygotsky (1978:86) to describe the learning process of a child as being "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers." On a collective level the ZPD refers to the distance between activity which is considered as unsatisfactory and the historically possible journey to a point where the identified contradictions are satisfactorily addressed (Engeström, 1987). In this study expansive learning cycle can be considered a ZPD of activity.

Chapter 1 Introduction

"And it ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things." Niccolò Machiavelli, *The Prince*, Chapter 6.

"As the physicians say it happens in hectic fever, that in the beginning of the malady it is easy to cure but difficult to detect, but in the course of time, not having been either detected or treated in the beginning, it becomes easy to detect but difficult to cure" Niccolò Machiavelli, *The Prince*, Chapter 3.

1.1 Introduction

This research forms part of preparatory work concerning the introduction of a national electronic health record (EHR) within Irish addiction services. The core feature of this system is the shared care plan (SCP) module which facilitates multidisciplinary activity between workers in what is known as EPS (Electronic Patient System). Accordingly, the research questions in this study attempt to understand what multidisciplinary workers are learning and what forms of interpersonal and organisational practice they are engaging with in this learning process when implementing the SCP. The study will use a Developmental Work Research (DWR) interventionist methodology which is designed to surface underlying contradictions within and between the activities which constitute the fragmented and demarcated practices of multidisciplinary workers within the addictions domain. Whilst this research is predominantly based on a Cultural Historical Activity Theory (CHAT) analytic framework the work of Bernstein will be utilised to address some of the theoretical shortcomings of the former by addressing institutional perspectives. Additionally the work of Bakhtin will be utilised to address the significance of understanding dialogism between participants. Finally, a critical realism theoretical perspective will be employed to appreciate the dynamics and other influences upon and between participants utilising clinical and non-clinical knowledge bases.

The background issues to this research will be explored by illuminating the complex multifactorial nature of drug addiction. This will outline the multiple perspectives, diverse issues and remedies in this area. In particular the study will seek to understand a social constructionism perspective of health and illness and its association with social problem analysis constructs. The role of the medical profession, patient and competing perceptions of drug misuse as a social problem will be discussed. A new direction for practice will be proffered which focuses on combining the efforts of all workers to engage in collaborative working based on a client-centred approach to form

care trajectories. The empirical work will use an expansive learning methodology, within a change laboratory setting, to address intrinsic tensions and contradictions between workers in order to form new practice to meet named policy aims and successful working within an EHR format.

1.2 Structure and content of the thesis

This introductory chapter will introduce the main concepts of this research prior to a more detailed explanation of them in the body of the thesis. A problem statement will address the issues pertaining to the subject area together with an appreciation of the study focus and rationale which aims to provide a practice-based solution to identified problems within current national addiction policy and services. The justification for using an activity theory approach will be stated. The research questions, aims, objectives and outputs will be clearly identified followed by an account of the significance of this research.

Chapter 2 will explore relevant issues, regarding social policy and practice, within the drug treatment domain, to reveal the different policy perspectives and accordingly their implication for the practice and management of drug addiction. The adoption of a social constructionism perspective towards the nature of the health and illness will allow an appreciation of how the client fits into current treatment and case management paradigms and the potential for client-centred collaborative practice. The changing role of the medical profession will be examined in an area which can be categorised as having both clinical and social problem dimensions. The potential for a new intervention paradigm will be explored in relation to multidisciplinary working and the construction of care trajectories. There will be a consideration of the potential of official discourse to be more inclusive towards clients' needs. This will be achieved by examining official efforts in relation to treatment models and whether such efforts are rhetorical and self serving or have real, potential benefit for clients regarding their involvement in the design and management of service delivery.

Chapter 3 will further examine Activity Theory and utilise Bernstein's framework for translating knowledge into pedagogic communication in order to make up for identified shortcomings. A Bakhtinian perspective will explore the concept of social language and multi-voiced understanding of communication in order to extend an appreciation of the occurrences within the SCP multifunctional device. Finally, a Critical Realism perspective will be considered to address areas of knowledge that are not addressed by the aforementioned theories and to appreciate a combined understanding of scientific and social domains.

Chapter 4 will construct the components of the developmental work research strategy, the use of a change laboratory approach and the use of D-analysis

as an analytical framework. Chapter 5 will describe and present the data analysis in a way that represented the occurrences within the change laboratory sessions as seen by the participants and in a way that befits the structure of this thesis. The final chapter will draw together overall understandings in the form of a discussion and conclusion chapter. In this way the merit and implications of the study can be considered in the light of the research questions and the significance of the research in terms of policy and practice.

1.3 Problem statement

Addiction services within Ireland form part of the social inclusion remit and as such involve a wide range of statutory and voluntary sector service providers. Clinical and non-clinical workers in these services have a wide variety of knowledge, skills and levels of training. Many of these providers work within a silo care group mentality and structure which results in fragmented and demarcated service provision with workers having adherence to different models of care and practice. The most marked difference in skills and activity of workers relate to those between clinicians and other workers. This demarcation involves issues relating to professional knowledge, ethics, confidentiality, skill and training levels. In essence drug treatment services are failing to deliver effective and efficient services due to problems relating to multidisciplinary and inter-sector working (Kothari, 2002; Cox and McVerry, 2006; Pugh and Comiskey, 2006). Vertical and silo models of service delivery do not address issues where one client may be in contact with several agencies none of whom communicate effectively together or succeed in establishing productive shared care planning and integrated care pathways.

The Health Service Executive Transformation Programme (HSETP) document outlines the need to reconfigure health services to provide easy access for patients within an integrated structure (HSE, 2006b). This implies effective interdisciplinary working with other agencies and workers across the health, criminal justice and social inclusion domains. This top down policy directive is setting interdisciplinary and integration objectives which workers will have to respond to by developing new forms of interagency collaboration, learning, practice and models of care. Current social policy is setting objectives in situations where professional practice has yet to be developed (Warmington et al., 2004; Daniels, 2004b; Engeström, 2001b).

National drugs policy has clearly identified problematic issues regarding multidisciplinary working and the continuity of care between agencies and sectors (DCRCA, 2009). 'The Introduction of the Opioid Treatment Protocol' (Farrell and Barry, 2010) reviewed, via consultation with all interested parties, drug misuse issues across all HSE and voluntary sector services, but excluding the prison service, to identify the issues, difficulties

and potential courses of action by which these issues could be addressed. The report made clear recommendations for action including the national roll-out of the EPS EHR to address many of the aforementioned issues. This research study forms part of the preparation for the national roll-out of EPS and it focuses on the development and utility of the SCP module within this IT system. The SCP module is the epicentre of multidisciplinary working and has the potential to enable inter-sector workers, across clinical and non clinical services, to engage in holistic care planning in a more efficient and effective way than heretofore. The HSE has actioned these tasks and the author has been given the role of national lead to ensure the successful roll-out of this IT system in conjunction with the Drug Treatment Centre Board.

1.4 Study focus and rationale

This research is concerned with multidisciplinary activity, learning and inter sector practice in the drug misuse field and is an effort to test the SCP proforma, in lieu of the SCP IT module, as a useful tool to enable this process. The SCP has embedded core concepts which include shared care planning, integrated care pathways and a care trajectory potential which is capable of addressing chronic relapsing conditions and incorporating clinical, psychosocial and rehabilitation discourses.

This study will undertake participatory research using Activity Theory and a Developmental Work Research (DWR) approach which views learning as a form of human activity that is situated in social situations and mediated by artefacts. By developing transformative models of professional learning using the SCP module (as a tool) workers can through particular ways of working (co-configuration and knotworking) create, via division of labour, the object of a new form of practice. In this way workers will generate a new form of collaborative practice to improve multidisciplinary practice and create effective care trajectories for clients.

1.5 Justification for use of an AT approach

This section will provide an introduction, justification and critical examination of the use of AT, as a relevant approach to answer the research questions and fulfil the aims and objectives of this research, which attempts to map out a paradigm for the next generation of multidisciplinary practice within care planning. It will explain the utility of such an approach and justify its use by contrasting it with other competing theories. It will be seen that AT provides an empirical framework which identifies problematic issues and contradictions and a delivery mechanism which can drive change. AT also has limitations as it can be seen to operate in a bubble defined by the experiences of those that employ its use and the concomitant limitations of

not appreciating the influences of other realities and institutional structures. AT can provide a hopeful approach for practitioners to productively change their working environments.

1.5.1 Description of AT

Activity theory is one of a number of learning-based theories such as situated learning which could be considered for use in this study. AT is not a full theory as such in that it is a framework for understanding learning. Section 3.2 provides a full account of its use. It is appropriate for this research because according to Engeström's (2001a) third generation development of the theory it answers four central questions:

- 1 Who are the subjects of learning – how are they defined and located?
- 2 Why do they learn – what makes them make the effort?
- 3 What do they learn – what are the contents and outcomes of learning?
- 4 How do they learn – what are the key actions of processes of learning?

Engeström allied these four essential questions with the development of five principles of activity theory into a matrix which can be used as a guiding structure, together with an expansive learning methodology, for undertaking work to address the aforementioned problematic situation. Blackler et al. (2000) provides a more detailed explanation of the processes associated with the four central questions.

Activity theory is summarised by Engeström (1999d) by way of five principles which can be viewed as a manifesto for work in this area and which will be explored more fully in section 3.2.2. For the time being these five principles of AT are:

- 1 Activity systems as a unit of analysis in relation to other network relations in other systems.
- 2 Multi-voicedness of such systems in relation to the individuals involved.
- 3 Historical legacy of such systems.
- 4 The role of contradictions in terms of tensions and possibilities for change.
- 5 The generation of transformation possibilities via collective learning.

Thus, the matrix combination of the questions associated with learning and the five principles of AT is succinctly expressed in Table 1.

Table 1: Matrix for the analysis of expansive learning

	Activity system as unit of analysis	Multi-voicedness	Historicity	Contradictions	Expansive cycles
Who are learning?					
Why do they learn?					
What do they learn?					
How do they learn?					

(Engeström, 2001a)

This matrix, which can be used at various stages of the research, can assist in managing research ideas and data as the process develops. Accordingly, AT provides a creative, empirical and participative process where individuals from diverse backgrounds can analyse and develop their own activity systems and by so doing undertake perspective shaping, perspective taking and perspective making processes (Blackler et al. (2000).

“It is the distance between the present everyday actions of the individuals and the historically new form of the societal activity that can be collectively generated as a solution to the double bind potentially embedded in the everyday actions” (Engeström, 1987:174). Chapter five will develop this matrix to present the data analysis of the DWR sessions.

1.5.2 Positive selection of AT

Activity Theory was selected because it provides a rich descriptive theory and empirical framework which can assist workers in being aware of the object and dynamics of their activity and the process and trajectory of object construction. In this way it addresses tensions and contradictions within and between activity systems and allows for the development of creative and collaborative efforts to progress them (Blackler et al., 2000:280). It also provides for learning and knowledge building and the potential for developing new practice, especially where old practice has resulted in problem issues.

AT is a flexible framework, which is compatible with other theories, which can address complex activity environments and assist in planning redesigns of distributed learning through loose designs. “Where we are at cross purposes, we must ask how we have come to be that way, and how we might use those contradictions to experience each other in more human and productive ways”. . . “If something unexpected – messy – happens when people use

those environments, AT can provide analytical lenses to understand what has occurred, and perhaps use it productively for teaching and learning” (Russell, 2001:322). AT has basic common principles outlined by Cole (1998) which emphasise the shared and social context of joint human activity based on use of tools. In this way tool-mediated collective activity promotes development and change. This is achieved by recognising that individuals, as active agents, develop themselves within contexts that are not necessarily of their own choice but with other individuals and tools which have influence.

AT provides the framework to construct the SCP tool, with embedded conceptual design components, to enable workers to focus on such a tool as a common object over time. In this way historical, current and future practice issues can be contemplated and analysed in relation to existing tensions and contradictions and, via an expansive learning process, produce change. Tools and artefacts are used in AT in order to change and improve practice and align them to social policy goals. The cultural and historical origins of AT ensure that individuals are located in the sociocultural context of their actions and activity systems. This characterisation of tools sees them as vehicles containing cultural knowledge and social experience. This is described by Leont’ev (1978), in terms of an extension of Vygotsky’s (1978) unit of analysis, as a collective activity rather than an individual mediated unit of analysis and it forms the basis of Engeström’s work in developing the third generation of AT and that of DWR.

The Learning in Work (LIW) project (www.bath.ac.uk/research/liw/index.html) also selected DWR as a methodology based on Vygotsky’s perspective on mediation and intentional action and by so doing developed Engeström’s approach towards CHAT (Edwards et al., 2009:174). Therefore, the selection decision of the LIW Project was based on using DWR as a way of examining emergent practices in order to promote new working practices. This approach incorporated a change agent tool, which was germinated and driven from activity theory development, to examine and accelerate emergent practices without any methodological concern about the influence of the researchers on the developing practice.

1.5.3 Possibilities of selecting other theories

Actor Network Theory (ANT) was considered as a theoretical underpinning for this research given its previous use in the IT field and its potential for combining human and non-human (IT and network) issues and its central concern with power issues as opposed to AT’s concern with how people work. Interestingly there are also some similarities and cross fertilisation potential between ANT and AT concepts which has been quelled by a degree of antipathy between some proponents of each approach (Spinuzzi, 2008). However, core criticisms of ANT accounts have been made in relation to “the inclusion and exclusion of actors; the treatment of humans

and non-humans; the nature of privileging and status; the handling of agency and structure; and the nature of politics and power in ‘heterogeneous engineering’” (McLean and Hassard, 2004). ANT accounts have been considered in some notable systematic reviews concerning EHRs whilst AT has not (Greenhalgh et al., 2009).

The possible use of ANT was considered given the potential influence of the SCP as a technological actant mediating with humans. However, ANT equates human and non-human actants on the same basis. AT addresses developmental issues and issues of competence and cognition and as such is better placed to describe how workers learn and develop resources (Spinuzzi, 2008:86). For example, Edwards et al., 2009:174) used DWR as it enabled them to examine emergent practices and identify ‘sense making’ by eliciting the learning process, practice development and the usefulness of tools involved.

However, there are problems with AT’s developmental account as it has difficulties with discontinuities “when the orbit is broken, the learning spiral is in an incomplete eddy, we have difficulty applying it. And these eddies are quite common in a network environment in which work fragmentation and ‘continuous partial attention’ (McCarthy and Boyd, 2005; Stone, 2006) are prevalent features of the work” (Spinuzzi, 2008:190). Thus, AT has difficulties with discontinuities and ANT has little to say about learning and training.

1.5.4 Criticism of practice-based approaches to learning

Theories such as AT, ANT and situated learning theory (Lave and Wenger, 1991) and those focused on occupations (Suchman, 1994) have difficulty in generalising their results due to the idiosyncratic nature and the specific environmental location of their results. However, they share common concerns in relation to active learning and collective and distributed involvement within social situations. Lave (2009:201) described this as “. . . there is no such thing as ‘learning sui generis’, but only changing participation in the culturally designed settings of everyday life. Or, to put it the other way around, participation in everyday life may be thought of as a process of changing and understanding practices, that is, as learning”. Knowing then becomes an essential part of doing.

The Change Laboratory (CL) intervention in this research addresses some of these issues in that workers are distributed knowledge sources, which via collective learning based on common complex practice situations, can be used as a potential development or pilot model. It does so by using applied empirical research in real life situations by addressing collective learning. In this way it allows consideration of knowledge and skills from outside official sources (such as evidence-based practice). Such an approach is preferable to an Action Research methodology because not all workers are represented in the research cohort and the actual IT EHR is also not available at this time. Action Research by providing an iterative framework for change does

not provide a framework to explore issues of power and control at a structural and social cultural level nor for the exploration of communicative action and the rules and division of labour. "We need to understand the principles of communication in terms derived from a study of the principles of social regulation at the institutional or organisational level . . . These mediate social relations and shape both thinking and feeling: the 'what', and 'how', as well as the 'why' and 'where to' of practice" (Daniels, 2009:113). Action research has also been criticised for being atheoretical, without systematic methods and unable to account for learning processes (Atkinson and Delamont, 1985).

1.5.5 Criticism of activity system work

Nardi (1996) reports reluctance on the part of some academic journals to include AT studies as it is supposedly an area that is too complex, time consuming and requires effort to learn its basic tenets. Perhaps it is not a place for some who are not prepared to make the required effort. Engeström (1999b:11), in an insight into his cognitive processes comments that:

"I also had to learn to ground my theoretical ideas in concrete cases and carefully documented ethnographic detail . . . The developmental interventionist needs to record, analyse and support these processes. The researcher needs to record and analyse also his or her own actions and interactions. Interventions themselves must become an object of rigorous study".

Ratner (1997a) contends that there is a weakness in the Vygotskian approach in that it fails to consider the effects of social systems upon psychological functions. However, Ratner (1997b) drew criticism from his fellow cultural psychologists for explaining the "relationship between practical social activity and psychological phenomena" by suggesting that ". . . cultural psychology informed by activity theory directs attention at reforming social institutions and conditions in order to enhance psychological functioning".

"Finally, because activity theory does not have a robust theory of the individual, other than the individual as society's gift, it does not envisage the learning needs of the individual who lives across the natural, practical and social domains simultaneously (Archer, 2000), and who needs the skills and knowledge to flourish in each. Unless we see the individual as relatively autonomous of the activity system, then we privilege learning in the activity system, and conflate the learning needs of individuals with the skill needs of their organisation or enterprise. They are different" (Wheelahan, 2007b).

Daniels (2008:1) identifies a significant weakness in AT and contends that ". . . much of the socio-cultural or Activity Theory research that claims a Vygotskian root fails to fully articulate an appropriate theory of social

structure and an account of how it directs and deflects the attention of the individuals it constrains and enables". Daniels (2008:168) develops "... an account of institutional structures as cultural historical products (artefacts) that play a part in implicit (Wertsch, 2007) or invisible (Bernstein, 2000) mediation."

"The point of departure I wish to mark is that it is not just a matter of the structuring of interactions between the participants and other cultural tools, rather it is that the institutional structures themselves are cultural products that serve as mediators in their own right." (Daniels, 2008:168). Chapter three will seek to address some of the aforementioned weaknesses, in an activity theory approach, by drawing upon other supporting theories.

1.6 Research questions, aims and objectives

Research Questions

- What are workers learning when they are involved in the multidisciplinary implementation of the shared care plan module and what implications may this have for theoretical understanding?
- What forms of interpersonal and organisational practice and dynamics are associated with this learning?

Aims of the research

- To focus the multidisciplinary and interagency working group on community networking and prisoner throughcare in order to address the following aims.
- To report on health worker perceptions regarding the implementation of the shared care plan module.
- To explore the implications for communication, interdisciplinary practice and organisational change.
- To develop and test a new model of professional learning similar to DWR and LIW interventions.
- To understand the user perspective in relation to emerging theory and relate to macro and micro perspectives.
- To understand the interdisciplinary communication and organisational processes that will impact on the users who are focused on a holistic client-centred process.

Objectives of the research

- To operationalise (develop and test) the SCP tool.
- To assist in the creation of a more effective form of multidisciplinary working (distributed system of expertise) mediated by the SCP tool.
- To develop worker collaboration and by so doing develop practice, policy and new divisions of labour guidance (horizontal and vertical) for boundary working between practitioners.

- To develop and model new practice, via the use of ‘contradictions’, formed by expansive and transformative learning within an expansive learning cycle (Engeström, 2001a).
- To contribute to developing new knowledge in CHAT elucidated by reflective systematic analysis within the empirical research process.
- To relate the research findings to HSE organisational development objectives concerning the transition to improved integrated care, furthering the HSE primary care strategy and chronic disease management.

Outputs

- To make a significant contribution to the development of activity theory in the health sector
- To translate the aforementioned understandings (via leverage) to enable staff to undertake the necessary change management process in developing new practice protocols in this area and successfully rolling out the SCP on a nation-wide basis.
- To be able to illustrate and define the inter-professional dynamics and processes in implementing shared care planning and use them to develop a new model of care for Irish addiction services.

1.7 Significance of study

Previous research using a DWR approach with drug treatment issues has not been undertaken. However, significant Finnish research has examined continuity of care issues between primary and secondary health sectors (Kerosuo and Engeström, 2003; Kerosuo, 2006). The LIW project examined multidisciplinary collaboration and continuity of care issues, including the development of a shared assessment device, in the child care domain. Significantly, the work of Daniels in relation to the institutional dimension has broadened the possibilities for applied research in this area and the potential empirical value of such an approach in high profile IT projects. One could comment that the technology is rarely the focus of problems despite spectres of social control dominance. It is generally the humans and the power relations between them that require management to ensure a democratic playing field in rolling out IT systems.

This study contributes to realising the recommendations of National Drugs Strategy (DCRAGA, 2009) and the Farrell report (Farrell and Barry, 2010) in relation to the successful roll-out of the EPS EHR and associated objectives of achieving more effective multidisciplinary and intersectoral working in order to improve the continuity of care for those service users with addiction problems.

There is a need for a new model of care in relation to shared care within EHRs and the use of a socio-technical perspective to involve users and

stakeholders. This accords with recommendations for a wider appreciation of the use and design of technology, for example, in respect of NHS IT development (Greenhalgh et al., 2007; Greenhalgh et al., 2009; Aydin and Rice, 1992:182). "Treatment research has been asking the wrong questions in the wrong way. Three necessary shifts in ways of conducting research are proposed: (i) the field should stop studying named techniques and focus instead on change processes; (ii) change processes should be studied within the broader, longer-acting systems of which treatment is part; and (iii) science in the field should be brought up to date by acknowledging a variety of sources of useful knowledge" (Orford, 2008). Orford calls for research which involves participants (clients and workers) and giving them a "greater voice than was possible with traditional methods".

This research endeavour will build upon the CHAT framework provided by Vygotsky and Engeström and will develop these insights in the healthcare domain to realise the potential for new practice.

"The notion of social practice, as an analytical concept, is theoretically unsaturated. That is, no particular ontological or epistemological position is entailed by the general notion of social practice, defined as structured human traditions for interaction around specific tasks and goals. Therefore the concept can be used with various conflicting philosophical and theoretical perspectives . . ." (Hedegaard et al., 1999:13).

In conclusion, the case for using AT as an appropriate framework to address working in a complex multidisciplinary environment has been made. A description and an analysis of the drug misuse environment follows.

Chapter 2 Literature review

2.1 Outline

This chapter will explore and develop relevant issues regarding social policy and practice within the drug misuse domain. In particular it will identify and address current concerns and tensions which are impeding multidisciplinary practice and efforts to promote integrated service provision (joined-up thinking and working).

The first section will provide an overall view of the drug misuse terrain to outline drug policy paradigms, a critical analysis of addiction issues in Ireland and a representation as to how those issues can be illustrated in terms of the structure of this thesis.

The second section will explore various conflicting perceptions of the sociology of health and illness and the potential of addressing them within a combined biopsychosocial approach (Engel, 1977). In this way clinical practice can be seen as having possibilities in relation to collaborative working with non-clinical workers with a psychosocial or rehabilitation (case management) background.

The third section will examine the role of the medical profession in relation to its broad involvement in the drug misuse domain. This involvement is sometimes defined within the medicalisation thesis, which contends that the medical profession is sometimes involved in a social problem area that is not appropriate for clinical interventions. This section will outline the development of this model and consider the suggestion that it is no longer relevant in terms of developing consumerism and new public management models. It will be argued that the medicalisation thesis should be reformulated in order to reflect current clinical influences on policy and practice and the utility of communities of practice and activity theory in mediating a new form of multidisciplinary accommodation. The work of Bleakley et al. (2011) will be examined to suggest new possibilities for such an endeavour.

The fourth section will examine the efficiency and effectiveness of case management models in relation to current social policy and practice and their potential to be embraced within an electronic health record. It will also explore how social problems are defined (claims making) and how these impact upon defining clients' needs and interventions as the basis of care trajectories.

The fifth section will briefly examine issues concerning the new public management debate, consumerism and the paradigm of chronic illness to illustrate their implications for the management of drug misuse. It will be argued that clients with a drug misuse problem have a reduced and passive

role in relation to their treatment which belies the rhetoric associated with strategic efforts to introduce client-centred models of engagement.

2.2 Introduction

What is reality? How is this reality constructed and managed from a client, policy and practice point of view, and in whose interests, and to what ends, and to what effect? The field of drug misuse is a complex and multi-factorial problem area in which there are numerous perceptions of the issues and the remedies by which they may be addressed. Such varied perceptions of reality are difficult to discern and accommodate yet such conflicting perspectives require appreciation if the needs of clients and appropriate interventions are to be planned and executed for the benefit of society and the individuals who experience addiction. Accordingly, this study will attempt to keep an open mind in relation to diverse views whilst examining the possibilities for providing an improved method of service delivery by multidisciplinary workers involved in the construction of shared care planning and integrated care pathways. By providing an overarching analysis of policy, practice and theoretical understandings it is hoped that the reader will be able to appreciate the context in which individual workers, through learning processes, can work towards developing collaborative and necessary new practices.

Current perspectives concerning the sociology of medicine represent a shift from a biomedical medical model to a critical one which incorporates the views of other professionals and patients who operate at the boundaries of health and illness. This shift involves a substantial critical element which questions the privileging of the traditional medical view from a socio-cultural and historical perspective (Nettleton 2006:12, Bleakley et al., 2008, Wainwright, 2008:3). Tables 2, 3 and 4 outline some of the territory in relation to policy and operational practice issues.

This chapter will critically examine relevant theoretical, policy and practice issues which will provide an understanding of current issues and the possibilities for change. In particular it will look at ways to understand the roles, identities and professional knowledge of different workers. This research will address current policy initiatives such as Action 47 of National Drugs Strategy (NDS) which directs plans for treatment on a continuum of care model and a key worker approach in order to achieve seamless service delivery (DCRCGA, 2009). Current social policy is setting objectives in situations where professional practice has yet to be developed (Daniels, 2004b; Engeström, 2001a). Recent developments in such practice via developmental research work and in particular 'Learning in and for Interagency Working' (LIW) herald the way for further development (Daniels and Edwards, TLRP-ESRC study ESRC RES-139-25-0100).

2.3 Overall view of the drug misuse terrain and a critical analysis of drug treatment issues in Ireland

This section provides an overall international and national understanding of the drug misuse terrain. Table 2 outlines drug policy paradigms. Table 3 provides a SWOT and PEST organisational analysis of the Irish drug misuse domain which will be of assistance when considering the possibilities for new collaborative working. The potential for developing a new paradigm, in the context of this research and the empirical possibilities for its use in everyday practice via an electronic health record (EHR), is illustrated in Table 4 in the form of a critical analysis of overall addiction issues in Ireland and a representation as to how those issues could be addressed by adopting a Developmental Work Research approach.

The management of drug misuse is a complex area which has a multi-factorial causation and widely differing perspectives among practitioners and policy makers regarding appropriate interventions which embrace health, justice and other domains within a social inclusion remit. Table 2 provides an overview of some of these perspectives.

Table 2: Policy implications of three drug misuse paradigms

Paradigm	Legalistic/repressive (new and old models)	Public health (Ottawa Charter model)	Sociological/economic
Problem definition	Substance use seen as deviant and/or pathological, or sometimes as just “wrong” (“old” model restricted to illegal drugs).	Drug use seen in terms of individual and social behaviours (lifestyles) that can impose risks for individual health and the environment.	Policies such as prohibition stimulate illegal markets, cause criminality and aggravate other problems.
Overall goal	Controls substances and suppress use (goal re alcohol and tobacco more similar in “new” model).	Strengthen resilience, promote health, minimise health and other damage (individual & population).	Normalise drug use to reduce crime, stigmatisation and other damage.
Emphasis on	Any substance use (more distinction of legal/illegal drugs in “old” model).	Problematic substance use (legal & illegal drugs)	Changing social attitudes, policies and legislation.
Approach	Authoritarian, paternalistic. Implies coercion, exclusion, stigmatisation, incarceration.	Stress on equal partnership, human rights, social inclusion, empowerment, responsibility.	Egalitarian, laissez-faire. Drug use seen as consumer choice of products in the market.
Legislation	Criminalise drug supply, use. Maximise prices. Reduce availability (“new” model includes alcohol, tobacco, prescription drugs).	Some regulation seen as necessary, e.g. to protect young, consumer protection but models vary (relative risk is key concept).	Legalise drug consumption. Regulate supply through general consumer and youth protection legislation. Tax sales as other products.
Prevention policy	All illegal drug use and non-medical use of prescription drugs unacceptable. Restrict possibilities to use alcohol and tobacco. Promote anti-drug attitudes (“Say no to drugs”).	Preferable not to use drugs but if use minimise risks. Promote healthy behaviour, lifestyles and environments.	Part of normal health and social education.
Treatment policy	Abstinence-orientated. Medicalisation of addiction may allow substitution treatment. May be linked to repressive measures.	Pragmatic (range of approaches). More distance from repressive measures.	Provide treatment services as part of general health and counselling facilities.

Harm reduction	Often seen as condoning drug use.	Central concept in policy.	Avoids harm from prohibition. Other harms reduced by education and information.
Information needs	Prevalence of use, profile of users, risk factors for use, anti-drug attitudes, deaths, drug-related crime. Measure reduction in drug supply, drug use prevalence and illegal behaviour markets. "New" model, also alcohol and tobacco.	Prevalence of problem drug use (legal or illegal) and health consequences, individual and environmental risk factors, lifestyles and risk behaviours, knowledge and health beliefs. Measure improved health behaviour and reduction in burden on health.	Monitor health and other adverse consequences, treatment and counselling needs, access and use by the young. Product information and quality (consumer protection). Production and sales data (taxation purposes).

(Hartnoll, 2004)

Table 2 outlines three different paradigms which provide explanatory frameworks. "Clearly delineated scientific paradigms are rarely found in real life in the drug field, especially in the interface between research, policy and practice" (Hartnoll, 2004).

"Scientific assumptions are intermingled with moral judgements, ideological assumptions and culturally-biased perceptions . . . much depends not only on how you look at things (through what spectacles) but also on what value basis and with what beliefs" (Hartnoll, 2004). These competing practice, policy and political influences permeate the drug misuse domain whether individuals are conscious of them or not.

Table 3: SWOT and PEST organisational issues

<p><u>Strengths</u></p> <p>HSE Transition and integrated services initiative. Movement towards SCP and ICP configuration embedded within developing commissioning of services. EPS EHR established.</p>	<p><u>Weaknesses</u></p> <p>Will staff overcome idiosyncratic knowledge bases and power bases? Fragmented, demarcated, silo driven services. Lack of audit and performance structures. No national model of addiction.</p>
<p><u>Opportunities</u></p> <p>Will diffusion of innovation occur? PCT structures can provide future location of services away from specialised MMT clinics.</p>	<p><u>Threats</u></p> <p>Will staff accept management challenges? Clinically dominated system not engaging or adopting psychosocial and rehabilitation pillars of NDS or best practice. Resistance to change. Potential threat to client confidentiality.</p>
<p><u>Political</u></p> <p>DCRCGA/OMD structure inappropriate. New DOHC structure replicates previous political structure but will it provide greater social justice and challenge to medical dominance (authoritarian discourse-Bakhtin)? Surveillance medicine possibilities. CJS not engaging with other sectors in relation to Action 43 NDS.</p>	<p><u>Economic</u></p> <p>Need for efficient and economic service delivery by using SCP and ICP incorporating SMART objectives and M&E. Need to rationalise service delivery. Clients inappropriately attending multiple services. Competition between agencies for referrals, resources and ultimately survival.</p>
<p><u>Social</u></p> <p>Current policy not reflecting views of all sectors in NDS. Possibility of new practice in ZPD. SCP addresses current practice contradictions and useful as a way of mediating relations between service providers.</p>	<p><u>Technological</u></p> <p>Plethora of unconnected Access type databases rather than a common one exemplified in EPS EHR. Real time instant access to whole system. SCP & ICP are design features of EHR. Flexible open design accommodates all client scenarios.</p>

Table 4: Diagrammatic representation of operational, practice and social policy considerations, in relation to drug treatment services, with the possibilities for change using a DWR approach.

Current Issues	Operational Impact	Social Policy Issues	Practice Issues	Issues for this project	Possible Future system benefits
Fragmentisation: Lack of common assessment tools & protocols.	'Death by assessment'. Multidisciplinary competitiveness and inefficiency.	Diverse and optional translation of national policies according to different agencies and task forces.	No EBP or standardisation of practice.	Contradictions in practice elicited and worked on as 'object orientated activity'.	Continuity and multidisciplinary coordination of care via SCP & ICPs.
Demarcation and duplication of workers and service delivery.	Unilateral decision making, planning and service delivery.	Lack of diffusion of innovation.	Variation in worker knowledge, skill levels and competencies. No national competency/training structure.	Development of SCP tool.	Integration of services and information sharing in developing care trajectories.
Use of different non-integrated care models.	Non-integrated practice and inefficiency.	Aim to operationalise Rehabilitation Report (2007) & NDRIC (2010).	Psychosocial element of methadone maintenance not fully recognised or implemented.	Costs benefit efficiencies.	Holistic client-focused service delivery.
Multidisciplinary working problems.	Different interdisciplinary allegiances, power struggles and skill/knowledge levels. Limited interdisciplinary protocols.	Insularity between clinicians and non-clinicians.	Multidisciplinary working not effective. Change management and diffusion of innovation issues defective. Power issues focus on inherent belief systems rather than on EBP.	Will use of DWR be effective? Can change labs, expansive learning and co-configuration be incorporated into operational practice?	Improved multidisciplinary working via co-configuration and use of real time SCP module with inherent democratic SMART and BOSS concepts.
Poor reporting of: M&E, PIs, research, epidemiology and strategic planning.	Lack of client need and longitudinal outcome evaluation or variance tracking.	No cyclical input of performance data and no translation of policy downwards	Little discernment of EBP. No national model of addiction treatment. NDRIC framework not being accepted or translated into practice.	Develop M&E potential. Discern the nature of official discourse.	Overall improvement of health gain. Reflect and encourage good practice. Identify practice which is lacking or not addressing client needs.

Current Issues	Operational Impact	Social Policy Issues	Practice Issues	Issues for this project	Possible Future system benefits
Use of outmoded bureaucratic models such as case management.	Top of head approach reflects low levels of practice? Variable use of case management.	Need to meet HSE transition & integration objectives by changing practice.	DWR translates policy objectives into new practice. DWR potential to identify and develop current practice.	DWR identifies contradictions and change lab facilitates new practice in ZPD	Movement of policy and practice via co-configuration to new model of practice and ZPD.
Clinical dominance/ colonisation of social problem domain?	Underdevelopment of rehabilitation and drug free lifestyle aims.	Appropriateness of clinical thrust driven by HSE Business Plan?	Develop new interprofessional model similar to LIW project.	Examine insularity of parallel services. Examine power issues. Examine client perspective.	Greater collaboration between HSE and voluntary sector. Potential of rehabilitation as a social movement. Realisation of greater social justice via a holistic approach and democratic involvement of all sectors (communitarianism).
Risk issues inadequately addressed: Confidentiality. Relapse, recidivism, overdose and BBV acquisition. Treatment retention.	Long treatment waiting lists. Inadequate service provision for chaotic planning due to lack of coordination of multiple services.	Lack of needs analysis. Outcome evaluation not related to adequacy of practice, outcomes or realisation of policy.		E-surveillance medicine. Possibility of inappropriate liaison with social control aspects of CJS.	Real time access to multi-disciplinary information lowers risk thresholds though it poses information sharing issues.
NDRIC roll-out.	Minimal impact on practitioners. Bureaucratic system based on old system of case management.	Based on Rehabilitation Report (2007) and associated framework. Bureaucratic case management. Need for next generation of practice to meet policy requirements.	Most agencies aware of it but not able or willing to comply. Amazingly no linkage or integration with clinical policy and practice.	Need to be aware of and support NDRIC thrust as it is national policy and contains embedded SCP & DWR concepts to develop change to next generation.	NDRIC will be seen as a current baseline which will be superseded by a more relevant next generation model. EPS with co-configuration and SCP pedagogic device will encourage change process.

Table 4 outlines current issues and problems from operational, practice and policy perspectives as well as indicating how this study could address them in order to achieve overall system improvement. This view reflects the author's opinion and will not be used to influence the efforts of the participants in the fieldwork setting. Essentially, Table 4 illuminates possibilities for a bottom-up collaborative change management process, using DWR to evolve new practice, in order to diffuse new innovation across drug treatment services. Section 1.3 extends this analysis by defining the problem definition and section 4.5 assists by profiling the participants' geographical area.

This section has outlined diverse views which oftentimes form the basis of worker value and belief systems concerning drug misuse and treatment possibilities. Such positions can change in terms of individual worker attitudes and policy remits. In Ireland there has been a move from the era of abstinence, to harm reduction, to the ascendancy of community partnership and rehabilitation. The current Irish economic crisis and the publication of the Opioid Review Protocol (Farrell and Barry, 2010) and National Drugs Strategy (DCRCA, 2009) heralds a new era of possibilities which again focus on the need for integrated working and collaboration across many organisations and workers within the voluntary and statutory sectors.

2.4 Exploration of a social constructionism view of health and illness

This second section will explore different perceptions of a sociology of health and illness approach to this problem area and considers the potential of addressing them within a combined biopsychosocial approach (Engel, 1977). In this way the possibilities of multidisciplinary and interagency working between clinicians and other key workers with a psychosocial or rehabilitation (case management) background can be explored. This will contrast medical perceptions concerning an empirical approach to pathogenic illness with a social constructionism approach.

The social construction of reality assumes that the social world is not a given reality with an inherent meaning but it is an intersecting domain formed by the people who make it. Therefore we construct our own understanding of the world we live in. Vygotsky's theoretical framework supports the role of social interaction in the development of cognition. The words social constructivism and social constructionism may appear to be used interchangeably in different quotations in this thesis so it is therefore useful to differentiate their confusing meaning at this stage. Constructionism is both a theory of learning and a strategy for its development via social interaction and practice. It emanates from the constructivist theories of Piaget and Vygotsky which recognises that knowledge is not just transmitted via learning but that it is created in the process of learning with others. Accordingly, constructionism builds upon the constructivist perspective of the learner as an active constructor of knowledge. It focuses on the process of learning and building with others which may involve the construction of an external artefact or engagement in an object-related activity. Constructionism is also being developed by other disciplines (social constructivism and constructivist sociology of science) and has consequences for perceptions of reality (Flick et al., 2004:89).

The sociology of health can be considered from various theoretical perspectives and Table 5 provides a simple overview. “Thus there are competing models of society as harmonious or conflictual, as a set of structures ‘doing things’, or of individuals voluntarily complying with their social role, and of sometimes complementary sometimes competing, role of class, gender and ethnicity in structuring unequal health outcomes in society” (White, 2002:7).

Table 5: A simplified overview of the sociology of health

Theory	Model of Society	Cause of Disease	Role of the Medical Profession
Marxist	Conflictual & Exploitative.	Putting profit ahead of health.	To discipline and control the working class; and provide individualised explanations of disease.
Parsonian	Basically harmonious and stable set of interlinked social roles and structures.	Social strain caused by meeting the demands of social roles.	Rehabilitate individuals to carry out their social roles.
Foucauldian	A net of power relations, with no one dominant source-administered surveillance.	‘Diseases’ are labels used to sort and segregate the population to make it easier to control.	To enforce compliance with ‘normal’ social roles; and to ensure that we internalise these norms.
Feminist	Exploitative and repressive of women through patriarchy.	Carrying out the social role enforced on women by patriarchal men; the medicalisation of a woman around her reproductive life cycle.	To enforce conformity with patriarchal norms of femininity and motherhood.

White (2002:7)

A social constructionism theoretical perspective contends that all knowledge is always changing and is based on human interaction and interpretation as opposed to the empirical nature of medicine. The social construction of medical knowledge and its application stimulates a rich debate with opposing views and perceptions concerning not only the nature of illness but the ways in which the problems, like drug misuse, are addressed and asks who determines what illness is (Friedson, 1970:206). Bury (1986a) provides a robust critique of social constructionism which confirms Friedson’s views concerning pathological reality and the real possibilities for effective treatment. For example, it could be argued, contrary to a feminist

perspective, if childbirth were left to nature rather than having clinical support there would be considerably more infant mortalities. Finally, Bury questions the relativism of competing views of reality. At the suggestion of Wainwright (2008) the contribution of Bhaskar (1978) to this debate is taken up, in section 3.5, as it allows for a critical consciousness when addressing scientific discourse as well as considering social, cultural, economic and political factors in order to resolve problems via transforming human action at any given juncture. Therein may lie the potential for a more collaborative engagement between clinical and non-clinical sectors.

Therefore, a social constructionism approach, which recognises the reality of a positivistic medical approach, in that diseases do exist yet are also “products of social reasoning and social practice” (Nettleton, 2006:17), can increase understanding of the issues in this domain. “A considerable part of the criticism of constructivism is devoted to the questions of the approach to reality, and it is for this reason that Mitterer (1999:486) insists ‘no kind of constructivism is of the opinion that “everything is constructed”’ (Flick et al., 2004). Nettleton (2006:17) outlines the major debates concerning health and illness within a social constructionism perspective. “The literature on social constructivism is diverse, but we might usefully examine it under five headings: the problematisation of reality; the social creation of medical facts; medical knowledge and the mediation of social relations; the application of technical knowledge; and medicalisation” (Nettleton, 2006:14).

Problems concerning an appreciation of reality are constructed via reasoning and development over time which in turn create possibilities for changing practice within particular contexts although they fall into the problem of relativism (Bury, 1986:151-2) as there is no scientific or positivistic basis to test it against. The social creation of facts implies that our ideas about medicine are not stable and vary or are displaced in terms of the latest medical facts or paradigms which are in turn subject to understanding within various discursive contexts. Medical knowledge can be seen to mediate social relations in order to create a sense of objectivity or what is accepted as normal. For example, in the drug misuse world clinical knowledge is used to address the reality of addictive behaviour even though it might have a socio-economic causation factor. This appears to be legitimate but has the effect of hiding, via a process of reification, the social circumstances which may have contributed to the cause of the problem.

The social constructionism debate within medical sociology is an important perspective even though it has moved from a rhetorical to an active participation mode for the client as covered in the following sections of this chapter. This is particularly so in the case of addiction treatment where socially contingent and subjective perceptions exist. This is not to deny the existence of disease, risk or harm or the requirement to strive for best and effective practice, but to acknowledge that it is the application of that knowledge (Friedson, 1970) within a social constructionism context which is important to consider. “The constructionist approach, through its assessment of the legitimacy of knowledge claims, therefore questions the basis of professional boundaries, which are revealed to be products of socio-political struggles” Nettleton (2006:29). “Furthermore, if these constructionist

ideas are taken at all seriously; there may be consequences for professional identities” Nettleton (2006:31). Knowledge claims and social problem construction are addressed in section 2.8.5.

In conclusion, this section has depicted a social constructivism perspective as a way of interpreting the social dimension of illness although it is recognised that illness is itself often a bio-medical reality as well as an ambiguous reality. A critical perspective might conclude that the involvement of a wide range of dubious and legitimate workers in the drug misuse domain has formed a hotchpotch of individuals with competing self serving aims often based on indiscernible knowledge bases and skills. Such activity, given government legitimacy and formed under the banner of community development and partnership could be considered as being connected by collegiate ties based on an uncorroborated and invalid knowledge and skill base. This cohort, oftentimes query the clinical and rational legitimacy of the medical profession by railing against substitution treatment on the basis of belief systems whilst accepting a harm reduction approach. The next section will address the legitimacy of medical intervention within the drug misuse domain.

2.5 Medicalisation thesis or colonisation model

This third section is concerned with the role of the medical profession in relation to its broad involvement in the drug misuse domain. The medicalisation thesis, as applied to this research, contends that the medical profession is sometimes involved in a social problem area that is not appropriate for clinical interventions. This section will outline the development of this model over time. Section 2.5 will assist in considering the suggestion that it is no longer relevant in terms of developing consumerism and new public management models. It will be argued that the medicalisation thesis needs to be reformulated in order to reflect current clinical influences on policy and practice and the utility of communities of practice and activity theory in mediating a new form of accommodation. The work of Bleakley et al. (2011) will be examined to suggest new possibilities for such an endeavour.

The medicalisation thesis, as applied to this research, questions whether the medical profession is sometimes involved in a social problem area that is not appropriate for clinical interventions. In particular, should medical interventions be focused on attaining drug free lifestyles for their clients and therefore reflect a social justice approach involving democratic working relationships via distributed working? The argument will not address the appropriateness or efficacy of clinical interventions (Friedson, 1970) and methadone maintenance treatment per se as this is accepted as necessary government policy and supported by evidence-based research (Amato et al., 2005) to address situations when a client may be at risk.

Whilst there have been various definitions of ‘medicalisation’ over the years Conrad’s (1992) definition and conceptualisation has been broadly accepted by many commentators in the field although it encompasses a wide variety of conditions. “[Medicalisation] can occur on at least three distinct levels. First, on a conceptual level, a medical vocabulary (or model) is used to ‘order’ or define the problem at hand; few medical professionals need be involved, and medical treatments are not

necessarily applied. Second, on an institutional level, organizations may adopt a medical approach to treating a particular problem in which the organization specializes. Third, on an interactional level, physicians are most directly involved. Medicalization occurs here as part of doctor-patient interaction, when a physician defines a problem as medical (i.e., gives a medical diagnosis) or treats a 'social' problem with a medical form of treatment (e.g., prescribing tranquilizer drugs for an unhappy family life)."

The medicalisation thesis (Illich, 1976) although now subject to challenge, can generally be considered as the application of the medical (disease pathology model) within the social domain of human behaviour. It can also be considered as process in which a dominant interest that has access to power and influence can define, via social construction, issues concerning health and illness. Therefore according to Illich (1976), on one hand the involvement of the medical profession could be viewed as a form of clinical iatrogenicity where harm is being caused, social iatrogenicity which is colonisation into an inappropriate domain and cultural iatrogenicity where medicine meets the aforementioned aspects of the opiate epidemic by attempting to solve the problems and creating an unnecessary reliance on itself rather than allowing the individual a better chance of adopting a drug free lifestyle. Davis (2006) is concerned that the early use of the medicalisation concept, whilst it originally included some legitimate organic considerations as well as social and ethical considerations, has by colonising parts of the wider social domain decoupled itself from erstwhile, but arguable, legitimate interests in defining illness by allowing non-medical others to become involved in the illegitimate use of the model.

The medicalisation thesis can be considered in terms of early and later phases of its history which also reflects the change from a strong version of colonisation to a weaker one. This developed from what was considered to be a legitimate role of the medical profession in undertaking control of perceived deviance, in its wider forms, to an unwarranted concern in the use of a social pathology model to influence human behaviour. The significance of the associated 'sick role' (Parsons, 1951) concept is still very relevant today and especially so in relation to its application to drug misusers as it has held various places along the deviant-legitimate client continuum. According to Conrad and Schneider (1980) medicalisation depicted how "deviant behaviors that were once defined as immoral, sinful, or criminal have been given medical meaning . . . thereby properly under medical social control."

The medicalisation thesis may now be considered as an outdated process which describes how social problems are colonised and defined within a medical remit. However, medicalisation is relevant to this research as it is argued that the management of drug misuse by the medical profession could be viewed as an example of medical colonisation of an area which requires other forms of interventions. Indeed whilst the medicalisation thesis, which heralded from early conceptions of a functionalist social control model, which regarded uncontrolled deviance as a threat to society (Parsons, 1954) has been regarded as no longer relevant (Wainwright and Callan, 2002:168). Both Illich (1976) and Zola (1972) also refer to the waning of medical influence due to increasing bureaucracy systems. This can take the form of bureaucratic roles such as co-ordinators who individually

and collectively can isolate medical practitioners and clinical knowledge from organisational decision making.

Recent movements in developing the role of client advocacy and community detoxification services herald a further movement towards respecting the client. Wainwright and Calnan (2002) draw on the work of Strong (1979) and later Williams (2001) regarding sociological imperialism which queries the actual power that the medical profession is supposed to wield and the rights of patients to decline interventions. They also point out the rising influence of managerialism in medicine that is eroding the supposed power base of medicine and the movement towards the development of an active patient role. These emerging influences are also impacting on new models of professional practice.

A conflict perspective views professional practice as being allied to the economic and political power base of society and as such it acts as a powerful agency in the legitimisation and reproduction of social class and its concomitant inequities (Esland, 1976). That is why, according to such a perspective, professionals are given legitimacy of function and why a medical model, which embraces morally neutral values when assessing individuals, is attractive in some quarters. It is argued that the professions, via their ideologies and organisational structures, define the problems and needs of others by using supposed value neutral knowledge (Edelman, 1977). Indeed, one of the most important and least helpful developments in the field of deviancy has been the "medicalisation" and "psychiatricisation" of social problems (Pearson, 1975:15). This conflict approach is limited in that "A crucial problem of theoretical Marxism is the inability of the theory to provide descriptions of micro level processes, except by projecting macro level concepts on to the micro level unmediated by intervening concepts through which the micro can be both uniquely described and related to the macro level" (Bernstein 1993: xv).

Sawyer (2002:300) suggests that a productive approach "... must include postulates about the two-way causal relationship between individual and social properties, including the internalization processes associated with development and the externalization processes whereby individuals affect social structure (Valsiner, 1998b)."

In the Irish situation the medical profession performed a volte-face in the early 1980s, due to the era of AIDS, which resulted in the medical profession discarding a moralistic abstinence model, in favour of methadone maintenance (public health model). The utilisation of harm reduction and transitional change models (DiClemente and Prochaska, 1998) were significant in changing the perception of drug misusers from being deviants, within a particular subculture, to patients with a chronic relapsing condition deserving of treatment. Many service users were accorded official disability status and removed from the live unemployment register.

There is another view that the medical profession have been utilised by government to address drug misuse because of the major social problems and social unrest that the phenomena created. Indeed, there were periods of civil unrest which resulted in community protests as well as a threat to society due to fears of increased criminality

and the spread of blood borne disease. This unrest was evident during the Dublin heroin epidemic, prior to the introduction of the MMT Protocol, although some would describe the phenomenon as a moral panic (Butler 2002a; Butler, 2002b; Butler and Mayock, 2005). Drug misusers were presenting to clinicians with serious problems such as deep venous thromboses, abscesses and unexpected deaths and this situation was compounded by some doctors abusing the prescribing of methadone.

In an interesting set of articles, which take the form of opinion and usually without detailed references, Furedi (2006:15) commenced a debate on medicalisation as heralding 'the end of professional dominance'. He argues that whilst the medicalisation thesis redefined what were social problems to suit medical dominance "the focus on professional interest tended to distract contributors from exploring the cultural influences that assisted the expansion of medicalisation". Furedi (2008) provides a more detailed analysis of this area by suggesting that the medical profession provides a strong cultural signal for patients to interpret their woes and validate their experiences with the danger of inducing powerlessness for the patient.

Over recent years many commentators have remarked on the decline of medical influence and indeed the validity of a generalised perceived notion of medicalisation. This has been variously defined as the de-professionalisation thesis (Haugh, 1988); and the proletarianism thesis (Oppenheimer, 1973); and the corporisation thesis (McKinlay and Stoeckle, 1988). This phenomenon has been precipitated by the emergence of regulation and control in the form of managerialism, clinical governance, evidence-based medicine, influence of the health 'bean counters', patients' group influences, and advanced nurse practitioners. However, it could be argued that medical imperialism still exists today as the profession manages to ensure firm gate keeping of practices. The integration and business plans of the HSE reaffirm medical dominance of addiction services which are subject to clinical governance despite the aforementioned bureaucratic influences. Importantly Davis (2006:17) notes the tendency to blur de-medicalisation with de-professionalisation as "... most significant developments that shape the process of contemporary medicalisation are generated outside the institution of medicine."

Current debates concerning the medicalisation thesis embrace a wide range of affected conditions. Bury (2006b:38) believes that it is not possible to generalise "without more first hand sociological materials". Bury (2006b:39) states "we need a more sociological and critical engagement with cultural forms if we are to assess their reach and impact. This also needs to take into account important points of resistance and rejection . . . inherent in the changing nature of health care today" (p.40).

In conclusion, there is a need to understand the contradictory activities of wider helping professions. The development of a client care trajectory and involvement of multidisciplinary activities often means that the service user is consequently subject to a strained identity and role set (Merton, 1957) as he is subject to different worker demands and expectations. Merton suggests that these strains are also played out between the multidisciplinary team members.

Multidisciplinary activities can also be contradictory for clients and some members of the multidisciplinary team in that there may be difficulty in accepting the reasons why some workers are generally accepted as having a legitimate authority to define the causes, values and treatment of what are social issues (Edelman, 1997). However, Edelman could be criticised for this overemphasis on the connotative as opposed to the denotative aspects of language of the helping professions. Perhaps the question relates to what degree do the rights of individuals (in mission statements, patients rights policies etc.) militate against what Edelman sees as the worst examples of professional practice? In terms of case management systems the professional use of language and the art of defining clients' need and what constitutes successful outcomes are subject to ethnopoetic influences in the way described by Pithouse and Atkinson (1998) in relation to case talk, case definition or case discussion. This includes 'good accounts' which can be associated with good narrative performance or allowing the work of juniors to be examined by others (Pithouse and Atkinson, 1998). Satyamurti (1979) suggests that professionals use language to "legitimate the way they were working and the kind of service they were providing" to the point that the social worker's perception of how difficult the client was to work with, is of more concern than the features of the case.

2.6 Possibilities for change within the Irish addiction services

Possibilities for change within the Irish addiction services rely on efforts to implement national policies and the monitoring of such activities within policy structures. The recent movement of drug misuse responsibilities into the Department of Health, from DCRCGA in June 2011 have retained existing structures but separated them into a policy and operational divisions. These structures represent a bureaucratisation (Warmington et al., 2004) of the process of drug treatment and the underpinning of policy objectives without a concomitant solution as to how these might be fundamentally addressed in terms of practice changes. These issues have been characterised in chapter one and have proven to be resistant to change. This study is an effort to effect change by engaging a set of workers, in the form of a pilot project, to address shared care planning and integration of services issues by addressing known multidisciplinary problems such as the insularity of the medical profession in terms of new practice development.

Bleakley et al. (2011:13) suggest possibilities for changing this discourse as they argue for a paradigm shift in insular medical education which limits effective teamwork to more collaborative working. This is a shift away from "long-standing structural, vertical hierarchies, based on technical expertise . . . [towards] adoption of democratic, horizontal structures that honour 'non-technical,' shared practices, such as communication. (We think that 'non-technical, while an established term, is both ugly and inappropriate - communication may be a 'shared capability' but it has highly technical components in sophisticated use)" (Bleakley et al., 2011:15). However, it is unclear as to how encompassing team work extends beyond intentions to address iatrogenesis, risks and include the patient, peer review and quality assurance as doctors "resent unnecessary bureaucratic surveillance" (Bleakley et al., 2011:16). Bleakley et al. (2011:193) do distinguish between the effectiveness of functioning between inter-professional and multi-professional clinical teams and refer to

Engeström's (2004) concepts of boundary crossing and co-configuration which are features of the former and include the mutual appreciation of team roles and collaborative working. The possibilities for including the medical and nursing profession in collaborative work exist, although the latter have expansionist ambitions, within this area in the form of nurse prescribing. The professional implications of such activities are taken up by Martin (2000).

Bleakley et al.'s (2011) concern with patient narrative is an important focal point for multidisciplinary working although the doctor patient relationship is seen as having prime importance particularly in relation to the training of doctors. Bleakley et al. (2011:201) explore an appreciation of the patient narrative in terms of a text and draw upon the work of Culler (2006) and Barthes (1997) and how text does not have fixed but multiple (productive) meanings which are located in a cultural historical context which can be variously interpreted by a doctor, patient and others and which have implications for the reality or rhetoric of patient-centred practice. This could very well be a useful line of research in examining the dynamic entries in the SCP module which involve interpretation of the client, the giving of a meaning and potential negotiation of that meaning, over time, in conjunction with others, as a care trajectory develops. According to Culler (2006:104) text is used to produce a phenomenon and to identify it as problematic and to make that text explicit or transparent for the reader. Within the SCP this involves various workers with distributed expertise assessing client needs and deciding an intervention and working collaboratively with others to pursue object orientated activity as part of a care trajectory as meanings are negotiated through practice.

"The advantages of this concept are, of course, greatest in non-literary disciplines, where we could say that the concept of text does three things:

1. It suggests that items under consideration should not be taken as given and that one should consider how they come to be produced, isolated, presented to attention
2. It marks the meaning of these objects as a problem that needs to be explored
3. It posits that the analyst's methods need to be considered, not just prior to the inquiry to decide what steps will be carried out, but in the process of treating the objects of study themselves.

Jameson writes, for instance, 'the notion of textuality, whatever fundamental objections may be made to it, has at least the advantage as a strategy of cutting across both epistemology and the subject/object antithesis in such a way to neutralise both, and focusing the attention of the analyst on her own position as *reader* and her own mental operations as *interpretation*'. Above all in the social sciences the notion of text challenges the idea that data are separate from theory and interpretation" (Culler, 2006:110).

Bleakley et al. (2011:205) refer to traditional medical history taking as a form of what sociologists call medicine talk as an impersonal list of symptoms which may not be improved by considering the patient as text as a way of becoming more patient-centred. "To do this, we need to develop the idea of 'rich' and 'close' readings,

sophisticated and innovative readings and most importantly collaborative readings". The authors suggest doctors become reflexive about reading patients and "capture the values that drive such readings" in order to avoid paternalism and to seek dialogue and be transparent and collaborative. "By reframing patient-centeredness as a textual intervention, we reinforce the view of narrative-based medicine that patient presentations are literary works, narratives and dramatic episodes. Hence, while a scientific eye is necessary, it is not a sufficient component of patient-centred practice" (Bleakley et al., 2001:208).

These interesting ideas focus our attention back to the patient or client and suspicions as to how accurately the client's position is involved, translated or subject to a worker's own interests despite references to client-centred working. Barthes (1997) warns of the implications of relying on aspects of author's identity and how this might be found or distilled in the meaning they attribute to their work. In the case of the SCP module how this is found in terms of the identification of client needs, intervention outcomes and the implications for hegemony within multidisciplinary practice within the client plan. The theory chapter will explore the potential for these ideas further. Interestingly, a Finnish research project "Implementation Conditions of Integration Innovations in Health Care: Organizational Volition and the Voice of the Client (Centre for Research on Activity, Development and Learning (http://www.helsinki.fi/cradle/hoidon_English.htm) are undertaking research in this area.

This section has illuminated possibilities for reflection and change in terms of the role of the medical profession and how it may be perceived by others. It has been shown that the medical profession can change their modus operandi and models in relation to the harm minimisation model. Workers need to consider the functions of their roles and how they perform them in relation to the 'active client'. In view of tensions between health workers regarding the performance and rationale of their respective roles there is a need to construct a new discourse, practice and division of labour between them. In this way identified differences between clinical and non-clinical sectors can be explored with a view to exploring changes of practice and worker identities in what Holland (1998:52) describes as a socially produced and culturally constructed 'figured world' "a realm of interpretation in which a particular set of characters and actors are recognized, significance is assigned to certain acts, and particular outcomes are valued over others."

"In other words, the social construction of appealing, culturally plausible artefacts in a figured world offers an opportunity for social change, one person at a time" (Holland, 2002:14).

Daniels (2008:162) suggests that we consider the concept of 'figured world' and the notion of 'subject' to examine the construction of the figured world and the process by which the subject perspective is formed. "It is through the deployment of his concepts of voice and message that Bernstein forges the link between division of labour, social position and discourse and opens up the possibilities for a language of description that will serve empirical as well as analytical purposes". This concern with voice and figured world will be taken up again in the Bernstein section in Chapter 3.

2.7 Practice issues and case management

This section will examine practice issues within the drug misuse domain from a non-clinical perspective. Whilst clinical policy guidelines exist in some HSE areas there is no national model of addiction or clinical policy. There would appear to be no formal linkages to direct discourse between clinical and non-clinical workers although some clinical teams have rehabilitation workers attached to them often they are excluded from meetings if clinical matters are being discussed. Within NDS there is an unquestionable belief and emphasis on standalone (from clinicians) case management models which were until recently developed from policy and practice within the homeless sector. There is a requirement to step back and examine the efficiency and effectiveness of current case management models in relation to multidisciplinary practice which is being furthered by the NDRIC framework and the lacuna that exists between clinicians and non-clinicians. The relationship between case management and how social problems are defined (claims making) and how these impact upon policy and practice will be discussed in the next section relating to the role of the client within current health strategy.

2.7.1 Practice issues

Current HSE policy concerning integration of services, multidisciplinary working and the implementation of the NDS actions, NDRIC framework and Farrell report exhort the necessity for improved integrated working practice and continuity of client care between workers in the health and social services sectors. This sub section will consider practice issues in relation to what constitutes learning and practice as well as the differential applicability of the various models of care that individual workers subscribe to. This focus includes an awareness of the differential knowledge and skill base of workers providing fragmented and demarcated services.

“The contemporary literature proposes that practice be based on social science theory and knowledge concerning communication, diffusion of knowledge and policy processes. It argues that dissemination and utilisation of research be given a far higher priority by both researchers and policy-makers. It suggests the need for a comprehensive repertoire of practices” (Jones and Sellig, 2004). Greenhalgh (2007) endorses this view as does the Irish Health Research Board (Keane, 2007). This is a difficult area to address given the tensions that abound in terms of multidisciplinary working and worker adherence to different knowledge structures.

“Practice development is about the ways in which practitioners engage with, and create knowledge with which they effect development in their understanding and practice of patient care” (Clarke 1998, cited by Clarke and Wilkcockson, 2001). “The one clear message from the study is the importance of close integration of learning, practice and knowledge development (or research), disaggregating these elements will result in dissonance between knowledge, practitioners and the organisation – rather like a car’s gearbox, if all the cogs do not move simultaneously the whole will seize” (Clarke and Wilkcockson, 2001).

Another practice tradition is evidence-based medicine and guideline implementation. This requires organisational as well as individual practice changes (Grimshaw et al., 2004). This tradition can also be used as a rhetorical touchstone to justify much that is inappropriate when the real use of this perspective demands rigorous use of the model in examining what are often uncertain and challenging practice areas. Greenhalgh (2007) draws our attention to the tension between rationalists who view the diffusion of research innovation into practice as being a linear activity 'like water passing through a pipe' as opposed to a contested social constructivist process.

The Health Research Board (HRB) and Council of Europe (COE) have also been concerned to translate the benefits of evidence-based practice (EBP) and research insights within local drug task force structures but with little success (Sinclair, 2006). The Health Research Board fared little better in their efforts to disseminate models of best practice under Action 91 of National Drugs Strategy and the EU Action Plan 2005-2008 (Keane, 2007). The HRB undertook workshops covering EBP in harm reduction as well as rehabilitation utilising "the logic-model as a framework for designing good practice interventions" and drawing from systematic reviews on 'what works'. Feedback from focus groups suggested that the evidence was not used, that it reflected an 'ivory tower' split between academics and local service providers and that the research is "often seen as complex and inconclusive. Services are usually planned using what was reported as 'a top of the head approach' - a mix of anecdotal evidence and personal experience – when deciding the most effective way to respond a particular problem" (Keane, 2007). This HRB effort was influenced by Proctor (2004) in relation to the dissemination of EBP in terms of motivating and identifying approaches and methods to facilitate this aim. It was also influenced by the use of 'knowledge brokers' translating research into relevant policy and practice (Lawrence, 2006).

In conclusion, Hartnoll (2004:67) reminds us that the integration of research is influenced by values and ideology particularly in areas of complexity such as drug misuse. It is therefore important to define problems and the solutions to those problems in a way that appears to link them in a rational way even if the means is irrational and there are more covert objectives. In the case of the SCP IT module it appears that the operational processes still come within the remit of the medical profession however the roll-out of the system will challenge existing models of care for both clinicians and non-clinicians by altering practice and power relationships. The problem is that members of the multidisciplinary team often only take responsibility for one component of overall activities. "That way rationality and coherence evaporate in the border zones between professions who do not understand each other" (Hartnoll, 2004:67).

2.7.2 Case management

Case management has been variously defined according to its function or the models that are incorporated from other fields. In terms of the NDRIC framework (Doyle and Ivanovic, 2010) it is probably best to characterise the Irish version as replicating the shared care planning, integrated care pathway and the four tier service structure found in the UK drug treatment model (NTA, 2002; 2006).

Additional support for the NDRIC framework was drawn from the Homeless Agency and Progression Routes (2009) protocols and especially so in relation to 'gaps and blocks' protocols to address interagency communication. A shared care plan conceptual model was derived from Pugh (2004:107).

"Many definitions of case management are available, though some writers prefer to describe the concept in terms of its functions, including assessment, planning, linkage, monitoring and advocacy. An important theme is that case management is an addition to good treatment, not a synonym or substitute for it" (McDonald, 2005).

Case management appears to have been axiomatically adopted without any analytical or critical exercise as acceptable practice in the Irish homeless and drug misuse sectors. There appears to be a general acceptance of its utility and effectiveness without any real consideration of the various models or their relevance to drug misuse (DCRCGA, 2007; DCRCGA, 2009). There are however serious concerns about the efficacy of case management generally and in relation to its application to the management of drug use. It would appear to be particularly unsuited to the new working dynamics associated with the introduction of the EPS IT system. This has implications for the careful development of the NDRIC framework (Doyle and Ivanovic, 2010).

2.7.3 The questionable efficiency and effectiveness of case management

There would appear to be difficulties in discerning the efficacy of case management due to limitations of the research on this subject in the psychiatric and drug treatment fields. In Ireland the Rehabilitation Report (DCRCGA, 2009) reflects a rational decision making model which seeks to address issues of continuity of care and the use of a case management practice by appointing a national drug treatment co-ordinator and a raft of local rehabilitation co-ordinators who will be tasked to develop a model of rehabilitation case management. The report fails to address the integration of rehabilitation and clinical services as well as continuity of care between community and prison services.

'The Australian alcohol, tobacco and other drugs strategy 2004-2008' also extols the benefits of case management in order to address the multiple and complex needs of clients. McDonald (2005) characterises case management as an ambiguous concept "the popularity of case management is out of proportion to its evidence of its effectiveness as an intervention". This review is descriptive in its commentary although it refers to substantive research and comments conducted by others that he accepts as methodologically sound. McDonald (2005) cites observations from the literature to outline some of the issues of concern regarding case management. These include separating the effects of case management from its particular context, the lack of proper description of the intervention, the lack of programme fidelity relating to good methodological design and weaknesses concerning an appreciation of extraneous variables. The list could be extended by asking questions concerning the variance of case management models and whether fidelity also involves keeping firmly to a rulebook of practice.

In the tradition of 'what works research' is case management effective in qualitative and quantitative terms (Rosen and Teeson, 2001)? These authors note that whilst it has been stated that there is robust evidence for the use of case management in a psychiatric setting this has not been translated into an acceptance of the model even in the form of Assertive Community Treatment (ACT).

Furthermore, two Cochrane systematic reviews (Hesse et al., 2007) have not confirmed the efficacy of case management for psychiatric patients (Marshall, 1996). However, these reviews selected only RCT papers and did not include many illuminating studies that did not meet their limited criteria. These reviews by limiting the definition and aims of case management introduced bias and a limited analysis of the diverse range of case management models and practice. Rosen and Teeson (2001) also inform us that in the case of RCT psychiatric reviews a similar limited analysis took place with the exclusion of ACT treatment types.

Furthermore, Rosen and Teeson (2001) bemoan the fact that no RCT trials of ACT have been conducted in the UK despite its proven efficacy. The authors suggest that this is the case because the trials that did take place did not meet the fidelity criteria for RCT. They also painstakingly catalogue the negative and unsubstantiated subjective view of the medical hierarchy in relation to case management. Rosen and Teeson (2001) comment on the impact of the Marshall et al. (1998) psychiatric case management review which condemns case management as an unproven intervention foisted upon unwilling services due to the political will of 'vested interests'. They also note that followers of case management were subsequently viewed as being influenced by 'religious fervour' or 'missionary zeal' (Holloway, 1999 cited by Rosen and Teeson, 2001).

Payne's (2000) analysis of UK case management development characterises the function of powerful political direction in determining practice rather than focusing on the professional concerns of workers to explore the value of several models and to develop sophisticated practice relevant for their situations and context. This represents a shift from focusing on the concerns of professional workers to one that has a concern with managerial (Wagner, 1998) and consumer interests (Griffiths, 1988) as exemplified in these government reports.

Unlike the UK there are no vested interests or antagonism in relation to case management in Ireland. This may have been due to an inadequate literature review in relation to Rehabilitation Report (DCRCGA, 2007). However, this report has had a profound influence on driving the rehabilitation agenda and enabling the possibilities for non-clinical interventions. Prior to the publication of this report the voluntary sector made a major effort to have responsibility for rolling out the rehabilitation pillar. However, the HSE took responsibility for this initiative and the medical profession, who displayed little erstwhile interest in rehabilitation, were keen to have the HSE colonise this area for fear of losing power over a developing move towards holistic care.

The deployment of designated case management staff, as in the Irish scenario, has according to McDonald, been criticised by a sound methodological research

undertaken by Friedman et al. (2004) which supposedly found that such designated staff failed to increase user access to services better than ordinary staff across “disparate systems of care”. However, closer examination of the Friedman research reveals admitted non-response bias in that the authors imputed missing data for 10 programmes which included 410 (14.5%) of clients rather than exclude these programmes from the analysis. This research also reported that case management was successful in terms of higher client utilisation of services rather than addressing client outcomes or other fruitful areas of process.

In conclusion, it can be seen that case management has always been a difficult form of practice to implement due to its various amorphous definitions, vague models of practice, various levels of skills between its practitioners and the equivocal research evidence. More contemporary use of this approach has seen its translation into interagency practice as characterised by HSE transformation programme priorities. These new targets have been set without a sound theoretical or practice base by which to meet such aims. Current practice reflects a systemic concern “with good practice interagency literature” and is characterised by the work of Atkinson et al. (2002) and Tomlinson (2003) according to Warmington et al. (2004).

“This level of literature is minimally concerned with the forms of professional learning that take place within interagency working and is largely atheoretical, in that its models of interagency working are not located within coherent theories of work, organisation or learning in practice” (Warmington et al., 2004).

Accordingly, tensions and conflict between agencies and workers are usually suppressed in teeth grinding fashion for the sake of good partnership working. Now may well be the time to directly address these tensions and move on to other more fruitful models of developing practice such as the use of co-configuration working as outlined in the methodology chapter. There is also a need to more fully understand the influences of social structure and the relations of power. “We need to understand the principles of communication in terms derived from a study of principles of social regulation at the institutional or organisational level (Daniels, 2010:380). Section 3.3 will provide the basis for such an understanding.

2.8 Consideration of the client perspective

This section will examine official interpretations of the client role in terms of client involvement in policy and client-centred practice. In particular it will focus on whether the new public management and consumerism models are influential in considering the role of patients or whether they are rhetorical devices conferring little benefit in changing their passive role. An examination will also be undertaken of chronic illness and patient-centred practice models.

2.8.1 Differences between policy and rhetoric in terms of drug treatment provision for clients

King (2011) examined the difference between policy and rhetoric in terms of drug treatment provision by conducting interviews with users and service providers and found that the former “were still being viewed in terms of old stereotypes of pathology, deviance and helplessness, with lip service being paid . . . in the planning and delivery of treatment”. This is despite national policies promoting a health gainful client-centred approach (DOHC, 2001). After all, drug users have human rights (Hunt, 2004) and legitimate expectations to achieve a drug free lifestyle by managing the care of their own bodies (Shilling, 2002).

Within the drug misuse domain harm reduction approaches have been associated with the need to involve users in terms of education, understanding their behaviour and accepting the chronic relapsing nature of the condition (Butler, 2002). Human rights arguments have also been employed (Hunt, 2004), with little official acceptance, despite references to ‘the virtues of ambiguity’ (Reinarman, 2004), save through the efforts of the Data Protection Commission, to safeguard the role of the service user. This lack of clarity regarding the service user role may be due to an apparent conflict with public safety issues (MacCoun, 1998:1206) or the dominance of “the war on drugs” philosophy (Murphy, 1996; O’Mahony, 2008) and the varying degrees to which these views hold prominence in the national consciousness.

National policy in this area, and its implication for individual practice, is confusing as there are no clear definitions of overall aims and treatment. Guidance is lacking in relation to substitution treatment and planning for a drug free lifestyle. This does not mean that a clear cut distinction or the pin pointing of a particular point of time can be made on the treatment continuum where clients can make a choice to move from one aim to another. But it does suppose that clients should be given some say about when a reduction in dose may commence and not have their views countermanded by a doctor. On the other hand client views may be unrealistic and expose them to risk.

“The current debate about abstinence and its safety and viability as a treatment option has at its heart this question of whether long-term addiction treatment and unaided abstinence are two different roads to travel, or are merely variants on an equally positive outcome” (Best et al., 2008).

“Why is sustained and treated recovery not the same? The fundamental premise here is that ‘treated recovery’, particularly that based on maintenance prescribing, is fundamentally different in aetiology and in character from abstinent recovery and that to create a taxonomy that classes them together is disingenuous and misleading” (Best et al., 2008).

“The philosophies and measures of success are different – good treatment outcomes tend to be measured in terms of public health and public safety – i.e. crime reduction and reduced spread of disease, supported by long-term retention in treatment. Because of the ‘chronic, relapsing condition’ assumption of maintenance treatments (O’Brien and McLellan, 1996),

retention in treatment is also seen as a success. As drug addiction is seen as being the equivalent of diabetes or hypertension, there is no 'cure' and so ongoing compliance with the treatment is seen as 'success'. For opiate addicts, this means indefinite prescribing. Here success is indefinite compliance associated with stable housing, employment and effective 'social reintegration'." (Best et al., 2008).

As Professor Clark asserted in the 21st April 2008 issue of Drink and Drug News "the main 'concern is the temporal course of addiction and how this influences the treatment system we should be offering to people'. If you have workers in a system that is predicated on a belief of crime reduction and chronic disease management, the self-fulfilling pessimism permeates the client and the worker and generates limited goals" (Best et al., 2008).

There is an argument that services should be explicit about the role of the drug misuser client and the authenticity of this role when compared to other HSE clients. Warmington et al. (2004) appropriately concludes this section by advocating a co-configuration approach.

"The issue of the dynamics existing between providers, the product or service and clients is central to the analysis of co-configuration. The cusped nature of current forms of work is reflected in the ambiguous relationships existing between providers and clients in many interagency initiatives and in the categories used by commentators to analyse such relationships. For instance, Powell (1997:157), drawing upon Pugh et al.'s (1987) categorisation of service user participation, distinguishes between . . . co-operation . . . collaboration . . . partnership . . . control" (Warmington et al., 2004:25).

2.8.2 The relevance of a chronic illness model in relation to the management of drug treatment

This section will consider whether it is appropriate to consider the service user in drug treatment services in the same way as patients with a medical chronic disease. The role and designated term given to the drug treatment 'service user' has been transformed over time by varying perceptions of the behaviour associated with drug misuse from official indifference, deviancy, medicalisation, moral weakness requiring abstinence, to one which defines the blood borne disease risk as the overriding concern in treating what may also be construed as a social problem.

Bury (1982; 1991) discusses the impact of chronic illness. He describes 'meaning as consequence' in terms of practical effects and 'meaning as significance' which affects a person's conceptions of himself. Perceptions of illness can also be viewed in terms of its impact upon personal identity (Charmaz, 1983), biographical disruption (Bury, 1982), stigma (Goffman, 1986) and in terms of labelling persons as deviant in order to control them or make them subject to pharmacological determinism (Becker, 1997).

McLellan et al. (2000) commented that drug dependence should be treated and evaluated as a chronic disease as there are similarities. He undertook a comparative analysis, based on a literature review, in the knowledge that arguments by analogy are limited, particularly given the voluntary initiation of what he contentiously describes as a disease process which may or may not respond to treatment. McLellan (2002) later queried, when considering addiction as a chronic disease, if we have been evaluating treatment effectiveness effectively or indeed providing the appropriate treatment. He explores the limitations of an acute care model. He discusses “the role of expectations and their effects on treatment practices” and the implications of attributing a continuing care approach which can make treatment attractive within the context of monitoring and coordination.

The HSE defines chronic disease management in terms of a generic population health model, rather than a disease specific approach, as “a system of co-ordinated health care interventions and communication for populations with conditions in which patient health care costs are significant”. The focus of these programmes is to prevent the health of an individual deteriorating, thus preventing the occurrence of acute episodes which may require hospitalisation” (HSE, 2006a: vi).

This approach is supported by underlying assumptions about the requirement for quality and safety of healthcare and patient experience (DOHC, 2001). It is also supported by proposed national standards. “Person-centred care centres on the needs and rights of service users, respects their values and preferences and actively involves them in the provision of care. Care should be based on what is important to the service user from their perspective” (HIQA, 2010:19).

The ‘HSE (2008) Transformation Programme 4.1: Chronic illness framework’ states “Chronic illness is defined as long-term conditions which can be treated but not cured”. This document, which provides no bibliography, lists nine key features which can be attributed to drug misusers if one assumes that they will not become drug free in the course of their condition. The document further states “It is recognised internationally that the management of chronic illness needs to change . . .” “Integration of services and access to self-care programmes have been found to be the most effective interventions to reduce the burden of illness”. The document outlines a population health framework which contains numerous aspirational action points.

The aforementioned documents are important in that they relate to what has been previously referred to as legitimate perceptions of illness and ‘the sick role’ (Parsons, 1951) and by corollary the official legitimacy of addiction treatment and the associated social inclusion framework which support clients. The crux of the matter is based on the questionable validity of using a chronic disease model. “If addiction is regarded as a chronic condition then it is possible that we have not been evaluating its effectiveness in the correct way” (McLellan, 2002). On the other hand if it is not a multiple or chronic disease, in the same way as diabetes or hypertension, is it still useful to manage the condition using a chronic disease model? Convenience would suggest that it is a hybrid model where there is a potential for abstinence and a possibility of a never ending continuum of interventions as the goal of attaining abstinence is not a compatible bedfellow within a treatment context for

many people. This is a live debate within the addiction domain as it challenges moral assumptions as well as the efficacy and cost benefit of long-term prescribing of methadone as opposed to achieving drug free lifestyle aims.

In conclusion, the case for perceiving drug misuse as a chronic illness has a common parlance although it has not officially been accepted as fitting within that nomenclature in the same way that Jellinek (1960) used the term 'disease concept of alcoholism' to promote the medicalisation of its associated behaviour. Von Korff et al. (1997) describe the essential elements of collaborative management of chronic illness as:

1. A collaborative definition of problems
2. Targeting, goal setting, and planning
3. Creation of a continuum of client self management and training
4. Active and maintained follow up of client progress.

Perhaps it is best to leave the chronic care paradigm as unfinished business, as drug addiction is not defined or limited by the pathological restrictions of the usual chronic medical conditions, yet there is merit in considering the status that chronic disease accords to drug misusers and its implications for care management.

2.8.3 New public management

This section will consider the role of public sector management in recognising the legitimate role of service users. There is an argument to be made for promoting respect or status for the client role and making an effort to focus on consumerism and new public management approaches within national drug policy. This assumes a rationality and common purpose with the client which is queried in some quarters.

Societal management of alcohol and drug misuse issues is complex and problematic due the multifactorial nature of the conditions themselves. Within existing bureaucratic structures there appears to be little consensus about policy aims whether they are contributed to by democratically elected representatives or unelected representatives who are on local drug task force and local area partnership committees. Recent characterisations of the drug misuse problem in terms of a 'normalisation' concept means there is cultural ambivalence about the use of drugs, how the issues can be defined and addressed from clinical, non clinical, community development and policy perspectives. Interestingly, Measham and Shiner (2009) develop their argument by examining the interplay between social structure and human agency to explain normalisation as "... a contingent process negotiated by distinct social groups operating in bounded situations".

Randall (2011), attempts to understand the rationality of Irish drug policy according to a theme previously described by Butler (Butler, 1991; Butler, 2002 and Butler and Mayock, 2005). Randall views official intervention as clandestine yet practically necessary as was the case when government officials responded to the previous Irish opiate epidemic in terms of harm minimisation efforts which probably would have met public resistance if they were subject to public debate. Randall's observations are located within the Irish version of the new public management or

'managerialism' debate. Such observations would not be congruent with some official policy makers. Randall interprets responses from nine semi-structured interviews with policy makers (including the responsible government minister) that research or evidence-based practice was not an identifiable influence on their views. No reference is made to the role, influence and publications of the National Advisory Council on Drugs a government organisation which has representation from many policy makers.

Randall (2011:292) characterises drug policy making as incrementalism in order to avoid potential mistakes "allowing for 'mutual adjustment' and protecting against lasting mistakes (Lindblom, 1959:81-82). . . Furthermore, it was argued that policy making in Ireland has a rather unique 'flavour' characterized by 'conservatism', 'compromise' and 'consensus'."

"Such approaches may also facilitate the disconnect between policy making and implementation as they bring much policy making into the partnership realm, diluting the policy-making power of individual departments and agencies. Policy and strategy can therefore be developed in relatively abstract terms with the power and responsibility for implementation delegated to individual government departments or bodies. Furthermore, such structures appear to dissipate decision making from central government to national, regional and local partnership structures. The importance of symbolism and political currency in the Irish context was identified particularly in the case studies" (Randall, 2011:292).

New public management models are associated with attempts to reorganise the workforce and the identities of the workforce by way of introducing self-governance and the management control of time and governance similar to Taylorism (Hood, 1991) and secondly by way of human resource management (Kirton and Green, 2000) by way of self-governance and good leadership involving learning and training. Many research papers still refer to the influence of NPM as they seek to explain organisational influences. It is arguable whether a new public management model ever took hold in Ireland particularly when one considers the formation of the HSE which combined rather than reducing staffing levels from the old health boards. Likewise, there is a similar lack of effort to reconfigure service models to meet current government efforts to massively reduce public services.

Dunleavy (1994) conceptualises NPM as the importation of business practices into public service by integrating the following themes: Firstly via, 'disaggregation' by splitting organisations into flatter structures and developing management information systems; Secondly, by 'competition', by way of introducing purchaser/provider separation of services to create competition and diversify service suppliers; Thirdly, 'incentivisation' by way of rewarding performance.

Dunleavy et al. (2006) argue that the new public management wave has now abated. "This ebbing chiefly reflects the cumulation of adverse indirect effects on citizens' capacities for solving social problems because NPM has radically increased institutional and policy complexity". There is now a new wave associated with "digital-era governance' (DEG), which involves reintegrating functions into the

governmental sphere, adopting holistic and needs-oriented structures, and progressing digitalisation of administrative processes. DEG offers a perhaps unique opportunity to create self-sustaining change, in a broad range of closely connected technological, organizational, cultural, and social effects.” This new wave has yet to hit and is evidenced in the dismal ability of Irish addiction services to monitor and evaluate the needs of its clients and the effectiveness of interventions (outcomes). This is a situation which can be resolved if EPS is successfully rolled out on a national basis.

Recent HSE policy imperatives and the proposed introduction of EPS can be viewed within a neo-liberalist public management doctrine which entails new organisational processes within the statutory welfare and voluntary care sectors. This impetus can be seen as part of the successful effort to establish rehabilitation as the fourth pillar of NDS. This organisational change process which is usually associated with a sole NPM initiative entails the development of new organisational processes such as the integrated services agenda contained within the ‘HSE Transformation Programme 2007-2010’ (HSE, 2006b) with implications for the division of labour and the blurring of boundaries between organisations, agencies and workers. In this way greater productivity and improvements for consumers are ostensibly prioritised above those of the individual or professional interests of workers.

2.8.4 Health consumerism

Health consumerism or patient empowerment is now increasingly referred to as partnership. This is an apparently benign concept which conjures up efforts to assist patient involvement in health services as underpinned by a number of HSE documents in this area (DOHC, 2008; DOHC, 2010; HIQA, 2010). Almond (2001) could not find an exact definition of consumerism but on the basis of her literature review devised the following definition despite concluding that consumerism is based more on rhetoric than the reality of evidence.

“Consumerism is a belief and attitude, which regards patients as powerful, active and sentient participants in structuring and developing health services. Their opinions and involvement to assess the quality and provision of services are sought and valued, and form a pivotal role in providing optimum levels of care for all. Consequently health services meet the needs of the consumers and not those of the professionals.”

Health service narratives have purloined the term consumerism to reflect what is or should be the patient experience and this is contained within patient charters, mission statements, agency visions, colonisation of patient safety, active citizenship etc. Again there are real differences of perception between what is rhetoric and reality in terms of patient experience. Consumerism in healthcare can also be seen as having a mediating role in addressing the gap between the distribution of limited resources and the demand from all socio-economic groups (Vabø, 2006).

Patient choice is a contested concept. “In short, if the reality of choice is linked to ideas of accentuated consumerist identity on the part of health service users, we

need to be very clear about whose understanding of choice is being employed, in what circumstances and the degree to which it reflects consensus on the part of the government, health service providers and patients” (Milewa, 2009).

“As Parsons observed . . . cultural norms and practices often help to shape the means by which incomplete or ambiguous knowledge (the basis of uncertainty) is expressed and dealt with in the relationship between clinician and patient (Parsons, 1951:449). But the physiological locus of identity, the body, straddles a notional division between public sphere of health policy and health services and the apparently private world of individual illness and well-being, particularly when access to healthcare is viewed as a ‘right’ . . . – are thus central to understanding what is meant by terms such as patient, citizen or ‘consumer’” (Milewa, 2009:172).

2.8.5 Consideration of drug misuse within a social problem paradigm

This section will consider the characterisation of drug misuse in terms of a social problem definition and the claims making conducted by workers when defining client need (assessment) and deciding interventions (treatment and rehabilitation) as part of shared care planning. This activity relies upon individual worker’s knowledge and skill base including their hegemonic claims when involved in multidisciplinary situations.

Social problems have been described by some commentators in terms of objective conditions and causes whilst social constructivists adopt a view that these problems are defined by the activity associated with such a construction (Spector and Kitsuse, 1977:75). Thus, medicalisation, according to this tradition, has re-defined deviant behaviour (Conrad and Schneider, 1980:1). “A social problem, then, can be defined as a condition that: (1) is widely regarded as undesirable or as a source of difficulties; (2) is caused by the actions or inactions of people or of society; [and] (3) affects or is thought to affect a large number of people (Farley, 1987:2)” (Best, 1995:3). The nature of social problems can be viewed from an objectivist and subjectivist perspective. Best (1995:5) informs us that the former has a common sense attraction whilst failing to consider the subjective viewpoint or the commonality between different problems.

“The central proposition of this tradition is that social problems are the definitional activities around conditions and conduct they find troublesome, including others’ definitional activities. In short, social problems are socially constructed, both in terms of the particular acts and interaction problem participants pursue, and in terms of the process of such activities through time” (Schneider, 1985).

Woolgar and Pawluch (1985) critically examine definitional perspectives in this area. “We speculate that the conceptual strategies and problems we identify in social problems explanations may be characteristic of all sociological argument which invokes a selective relativism with respect to the phenomena it seeks to explain.” In other words social problems could be expressed differentially according to the identity, aims and remit of workers involved in any collaborative process.

Within this overall debate there is a distinct divide between strict constructivists and subjective constructionists. Woolgar and Pawluch (1985:216), who are subjective constructionists, contend that constructionism is internally inconsistent by selectively discriminating between objective conditions in what they call “ontological gerrymandering”. This involves placing a boundary between assumptions that are understood and those that are not and by so doing “creates and sustains the differential susceptibility of phenomenon to ontological uncertainty. Some areas are portrayed as ripe for ontological doubt and others portrayed as (at least temporarily) immune to doubt” (Woolgar and Pawluch (1985:216).

However, Woolgar and Pawluch (1985:224) seek to illuminate rather than criticise such a tradition and see that it has potential for providing guidelines for such explanations as well as highlighting definitional weaknesses in terms of a selective relativism in attempting to explain a phenomenon. Spector and Kitsuse (2001: xi) respond to their critics by suggesting that social problem analysis be considered in terms of the process and activity of the individuals or groups making claims. “This definition proposes that any such claim may become a social problem, and focuses research on the *process* by which claims are assembled and asserted by claimants.” The central point is that a claim is made in relation to social conditions or problems. Whether the latter exists or not is not material save that the objectivists see social problems as conditions and constructionists focus on the claims making activity.

However, there is much critical opposition to constructionism which centres on constructionism’s alleged failure to recognise the realities of social problems and the powerless of those who are not able to make their own claims, and to rely on moral and political biases which in turn is alleged to be based on sociologists’ propensity towards liberal and egalitarian views of change (Best, 1995).

“The successful social problem explanation depends on making problematic the truth status of certain states of affairs selected for analysis and explanation, while back grounding or minimizing the possibility that the same problems apply to assumptions upon which the analysis depends” (Woolgar and Pawluch,1985:216). The ensuing debate resulted in a call for a middle ground (contextual constructivism) which concentrates upon viewing claims making as a process which avoids the misuse of assumptions in developing a faulty analysis (Best, 1995:346).

Schneider (1985:223) reviews and critiques a constructivist view of the sociology of social problems. He notes “An important source of both confusion and disagreement among those using a constructionist perspective is the question of how conditions should figure in social problems analysis”. He goes on to note that this is sometimes illustrated by “alternative accounts of what is (the “meditative position”), and the view that these accounts, definitions and claims are “constitutive” of reality” (Berger and Luckmann, 1966:224)

Whilst these confusions exist for sociologists they also exist for professional workers. Spector and Kitsuse (1977 p78) suggest a viability conceptualisation as to whether claims are defined as having viable claims and definitions: the viable ones ‘are those that ‘live’ and those claimants can ‘get away with’ (Schneider, 1985:224). “When

professionals become social problem participants, they must often share definitional prerogatives with diverse individuals and groups (see Weiner, 1981). Ownership does not always ensure complete control” Schneider (1985:219) . . .”. “Those that could establish their prerogatives to define the problem and designate who would be responsible for it were powerful figures in these social dramas (Gusfield, 1975, Latour, 1983; Peyrot, 1984)” Schneider (1985:220).

This outline of social problem construction has direct implications for individual and multidisciplinary assessment and construction of the shared care planning process. Often many agencies are involved with one client and they can all work in splendid isolation or attempt to collaborate or to work relationally at organisational boundaries by way of distributed expertise (Edwards and Kinti, 2009) within a stable (team) or unstable (knotworking) community of practice.

It could be argued that claims making in relation to social problems can be a competitive distraction from effective care planning. There are other more effective ways of addressing differences between claims makers by using a forum in which the distributed expertise of workers is employed to explore “. . . the collaborative and discursive construction of tasks, solutions, visions and breakdowns and innovations” across systems, rather than just being considered from an individual professional viewpoint (Engeström and Middleton, 1996:4). Edwards and Kinti (2009:128) state “We suggest that access to the meaning-making of other professionals groups is one of the major challenges in the interprofessional work we studied”.

Taking up the aforementioned idea of “meditative position” it is useful to consider the notion of boundary at this juncture given its impact upon organisational and professional difference. This relates to the negotiation of social problems and how they might be defined. Boundaries can be seen as sites for action in negotiating; meaning of different professionals (Edwards and Kinti, 2009), new practices or as a means of analysing the past (Engeström, 2007a). Daniels et al. (2009:3) “use the idea of organisational barriers, thought of in terms of boundary strength, as a means calibrating the setting in which cross-boundary developments take place”. This accounts for the differential boundary strengths between professional workers and the way in which they mediate practice. In conclusion there is benefit from viewing social problem resolution as a collaborative activity for both clinicians and non-clinicians. This activity will occur within the SCP arena and involve tensions, contradictions and the differential functioning of workers in their professional roles and their claims in respect of the client.

The next chapter will consider these possibilities within various theoretical frameworks. It is therefore useful, at this point on the threshold, to contemplate Bakhtin’s (1981) concept of ‘ideological *becoming*’ *when considering a social problem analysis*. Bakhtin’s concept of “ideological becoming” refers to how we develop our way of viewing the world, our system of ideas, what Bakhtin calls an ideological self. Bakhtin is concerned with more than individual growth, since he places the individual firmly within a social context and shows that the individual influences the social world just as the social world influences the individual. This is dependent upon effective communication across the boundaries that separate individuals and the opportunities for learning that occurs in these places.

Chapter 3 Theory

3.1 Introduction

This chapter will explore a range of theories, which are mutually complementary, in order to further understanding of learning within multidisciplinary working. The chapter will be sectioned according to each theoretical approach but will also compare and contrast differences and commonalities between those individual theories and their significance in relation to the shared care plan tool. Accordingly, the following sections will discuss Activity Theory, Bernsteinian, Bakhtinian and Critical Realism theoretical perspectives utilised in this research and the ontological and epistemological assumptions that underline their use. It will justify their consideration and address the strengths and, weaknesses of each approach and comment on their mutuality in supporting this research effort.

Ontology is concerned with ideas about the nature of reality in terms of its composition and causal powers. The literature review outlines the diverse policy and philosophical approaches in relation to international and national drug policy as well as outlining the different knowledge bases upon which practice is formed. Epistemology relates to arguments that can be made about how one can acquire knowledge about reality. This depends upon the ontological position that is enlisted to forward a particular theoretical argument, which in turn forms the basis for developing the logical process of a research strategy, the methodology adopted and of course the results obtained. Therefore, questions about what is real and how one gains a better understanding of reality are influenced by the theories that are adopted. This in turn is influenced by the perspectives and knowledge bases of the workers and the working relationships being studied. For example the medical profession generally adopts a positivistic ontology based on observable phenomenon, predictive theories and a scientific appreciation of the world whereas those with a social science background tend to view reality as being constructed by the meanings attributed by individuals. There are therefore multiple and subjective perceptions of reality which cannot necessarily assume that all factors are observable. The necessity to call on several theoretical approaches assists in addressing deficiencies within each and hopefully assists in calls for clarity of epistemological and ontological positions (Daniels, 2008:114).

“Methodology is not a ‘tool box’ of different methods from which the researcher selects some on the basis of personal or social preferences. Instead, it is an integrated structure of the epistemological process (Branco & Valsiner, 1997) that can equally and easily reveal and obscure the empirical reality in the knowledge construction process of social scientists” (Diriwachter and Valsiner, 2005:8).

3.2 Activity Theory

This section builds upon the introduction and justification for the use of AT used in section 1.5 and relates to section 4.4 concerning the description of expansive

learning and the change laboratory approach. This section will describe the principles of AT in greater depth and outline the historical nature of its development into a form of intervention known as developmental work research. This is the approach which the LIW research utilised and upon which this research has modelled itself.

Activity Theory was developed by Vygotsky and his followers in the late Soviet Union during the 1920s and 30s in an era of state control and challenging restrictions relating to the development of new ideas. This creates some ambiguity in interpreting early texts and fully understanding some subtleties in meanings. Vygotsky's central concern was to focus on learning between humans and their surroundings and the way in which they are mediated by cultural expressions, tools and signs. It is important to clarify the differences between activity theory and cultural historical activity theory by recognising that the former relates to a Russian approach involving scientific and management studies as opposed to the latter with a more western approach addressing explanatory principles as exemplified by the work of Engeström and known as Cultural Historical Activity Theory (Daniels, 2008:117,121).

3.2.1 Three generations of Activity Theory

Activity theory can be seen to have been developed through three generations since its initial conceptualisation (Engeström, 1999a).

First generation of AT

The first generation focused upon mediation as illustrated by Figure 1 which is expressed by a stimulus and response connection and is transcended by "a complex mediated act to form the more commonly expressed as the subject, object and mediated act triad" (Vygotsky, 1978:40).

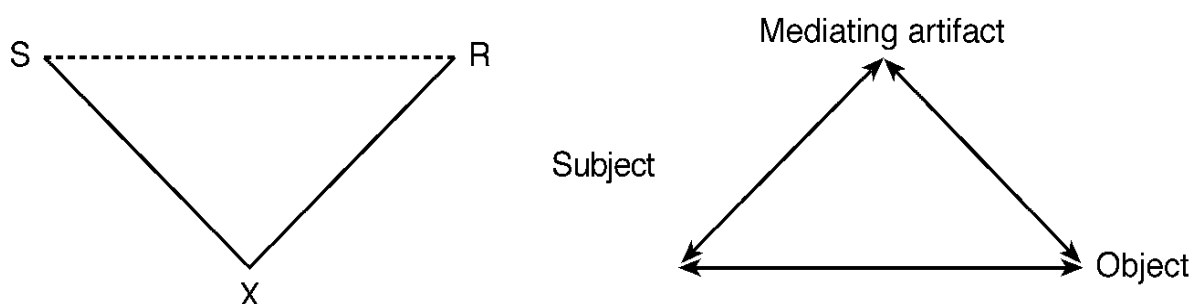


Figure 1: (A) Vygotsky's model of mediated act and (B) its common reformulation

The individual could then be seen together within the context of their cultural artefacts. In this way they have an impact upon their surrounding world as seen by

their focus of the object of their activities. This is the idea of object motive which is necessary for understanding human motivation.

Second generation of AT

To move understanding from the individual to the collective Leont'ev (1981:210-213) developed the second generation of activity theory, which he illustrated by an example of “primeval hunt”, without graphically altering Vygotsky’s model. This was later depicted by Figure 2 with the apex of the triangle representing individual and collective actions within a collective activity system.

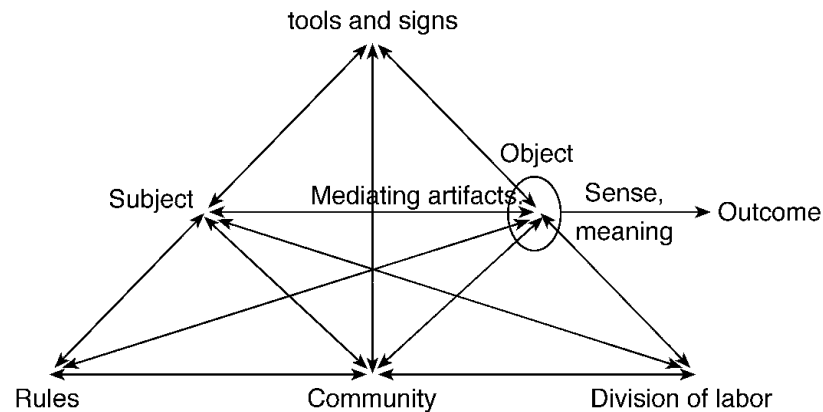


Figure 2: The structure of a human activity system (Engeström, 1987:78)

The second generation model introduces artefacts “as integral and inseparable components of human functioning” which include other factors when one examines their mediated relationships (Engeström, 1999a). This figure will be used together with a modified version to include the dynamics of the research participants’ world as mirror data within the DWR sessions.

Third generation of AT

Third generation activity theory expanded the development of the theory further, as shown in Figure 3, by incorporating the concept of internal contradictions as a driving force for change, the incorporation of multiple perspectives and networks of different activity systems and the incorporation of ideas from other theorists included dialogicality and boundary crossing (Engeström, 2009).

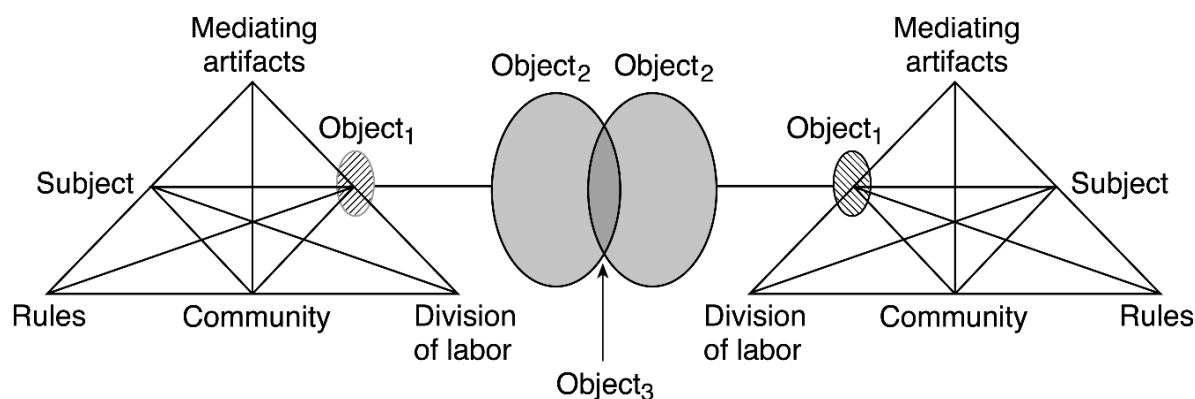


Figure 3: Two interacting activity systems as minimal model for the third generation of activity theory (Engeström, 1999a)

“Third-generation activity theory endorses the fact that all activity systems are part of a network of activity systems that in totality constitutes human society. Diverse activity systems are the result of a continuous historical process of progressive job diversification and collective division of labor at the societal level (Marx, 186/1976). Thus, during societal development, . . . the network is formed as activity systems lose their self-containment and exchange entities, including objects, means of productions, people, and various forms of texts. The first activity system is understood as a concrete universal, which particularizes itself into many mutually constitutive activity systems” (Roth and Lee, 2007:201).

“The third generation of activity theory, as proposed by Engeström, intends to develop conceptual tools to understand dialogues, multiple perspectives, and networks of interacting activity systems. He draws on ideas on dialogicality and multivoicedness in order to expand the framework of the second generation” (Daniels, 2001:91). Engeström through his development of three generations of activity theory has pointed out five principles of AT, which were outlined in chapter 1 section 1.5.1, and illustrated as a matrix for the analysis of expansive learning in Figure 1 (Engeström, 1999d:4-5).

3.2.2 Five principles of AT

“The first principle is that a collective, artifact-mediated and object-oriented activity system, seen in its network relations to other activity systems, is taken as the prime unit of analysis. Goal-directed individual and group actions, as well as automatic operations, are relatively independent but subordinate units of analysis, eventually understandable only when interpreted against the background of entire activity systems. Activity systems realise and reproduce themselves by generating actions and operations.

The second principle is the multi-voicedness of activity systems. An activity system is always a community of multiple points of view, traditions, and interests. The division of labor in an activity creates different positions for the participants, the participants carry their own diverse histories, and the activity system itself

carries multiple layers and strands of history engraved in its artifacts, rules, and conventions. The multi-voicedness is multiplied in networks of interacting activity systems. It is a source of trouble and a source of innovation, demanding actions of translation and negotiation.

The third principle is historicity. Activity systems take shape and get transformed over lengthy periods of time. Their problems and potentials can only be understood against their own history. History itself needs to be studied as local history of the activity and its objects, and as history of the theoretical ideas and tools that have shaped the activity. Thus, medical work needs to be analysed against the history of its local organisation and against the more global history of the medical concepts, procedures, and tools employed and accumulated in the local activity.

The fourth principle is the central role of contradictions as sources of change and development. Contradictions are not the same as problems or conflicts. Contradictions are historically accumulating structural tensions within and between activity systems. The primary contradiction of activities in capitalism is between the use value and exchange value of commodities. This primary contradiction pervades all elements of our activity systems. Activities are open systems. When an activity system adopts a new element from the outside (for example, a new technology or a new object), it often leads to an aggravated secondary contradiction where some old element (for example, the rules or the division of labor) collides with the new one. Such contradictions generate disturbances and conflicts, but also innovative attempts to change the activity.

The fifth principle proclaims the possibility of expansive transformations in activity systems. Activity systems move through relatively long cycles of qualitative transformations. As the contradictions of an activity system are aggravated, some individual participants begin to question and deviate from its established norms. In some cases, this escalates into collaborative envisioning and a deliberate collective change effort. An expansive transformation is accomplished when the object and motive of the activity are reconceptualised to embrace a radically wider horizon of possibilities than in the previous mode of the activity. A full cycle of expansive transformation may be understood as a collective journey through the *zone of proximal development* of the activity” (Engeström, 1999d:4-5).

Cultural Historical Activity Theory (CHAT) provides the basis for using methodological tools (such as DWR) for examining the ways in which social, cultural and historical factors influence human functioning. Daniels et al. (1996) point out the importance and need for empirical research to consider appropriate post-Vygotskian theoretical frameworks “for a structural description of social settings which provides principles for distinguishing between social practices.”

Accordingly, this research will empirically utilise a CHAT perspective, via Developmental Work Research, via expansive learning, to examine how workers learn a new way of working with the assistance of the SCP tool. At present many workers in Irish addiction services appear to operate independently with clients, who

may also interact with other workers, in the absence of multidisciplinary working or case reviews. The use of the SCP module within change laboratory (CL) sessions in the fieldwork will assist workers in understanding how other workers function and how they, following the identification of tensions and contradictions, might be able to collaboratively work with other workers by devising a new form of practice. This is a particularly challenging task as learning is a transformation process which requires workers to address multidisciplinary tensions and to collaborate across professional and institutional boundaries. CHAT depicts learning as involving the internalisation of ideas that are culturally valued and that the subsequent process of their externalisation is a transformative process. In this way workers are subject to the influence of the social context in which they live.

At a micro level of analysis each worker, within an effective multidisciplinary team context would be in a better position to undertake a client needs analysis (assessments), and agree intervention tasks (treatment), by devising a care trajectory for their clients. This would then transform insular worker activity which is often fragmented and demarcated. If the conceptual structures of shared care planning (SCP) and integrated care pathways (ICP) become guiding aims, as they are embedded within the conceptual design schema of the SCP module, then a new form of multidisciplinary practice could be realised based on the features of distributed expertise and co-configuration working. This is a big call given the varied pedagogic practices of workers and the power relays and institutional structures within which they operate.

However, CHAT whilst aspiring to recognise that individuals are shaped by their social contexts does not provide a theoretical framework in which to interpret the macro perspective to the micro perspective of activity and that is why the theories of Basil Bernstein, which are addressed in the next section, are required to understand these contexts which impact upon workers and the life world of their clients.

3.3 Bernstein's framework for translating knowledge into pedagogic communication

This section will outline Bernstein's sociological framework of knowledge and regulatory structures in order to appreciate the influence of structure and power in this study. It will discuss the strengths and weaknesses of this approach. In particular it will describe the pedagogic device concept and relate it to the SCP module and its function as a multidimensional device in understanding pedagogic practice. The crucible of the SCP module (tool) contains the regulatory structures that demand additional theoretical understanding if issues relating to scientific and everyday discourse, the division of labour, power, pedagogic practice and professional hegemony are to be addressed. In this way the dynamics of multidisciplinary working can be appreciated within the working arena of the SCP.

This section will support the aforementioned AT section in addressing the aims of this research and by so doing extend the influence of a CHAT approach. It will, through a Bernsteinian understanding, provide "... the language of description for

moving from those issues that activity theory handles as rules, community and division of labour to the discursive tools or artefacts that are produced and deployed within an activity” (Daniels, 2008:155). Bernstein’s sociological framework, makes up for the deficit in Vygotsky’s approach, by facilitating an analysis of changing forms of cultural transmission and by pointing out the processes which regulate the structure of the tool not just its function (Daniels, 2004:178). This will assist our understanding of how society, selects, classifies, distributes, transmits and evaluates knowledge and how it can be applied empirically within the organisation and institutions in which workers operate. It is arguable that if current work practices are failing to achieve the integration required in order to achieve organisational objectives, then collaboration in the development of new integrated work practices is required. Such collaboration will necessitate the weakening of boundaries separating practitioners. This in turn will have an impact upon the differential roles, skills and knowledge bases separating workers (subjects) and the manner in which they are realigned in order to formulate new practice.

3.3.1 Bernstein’s knowledge structures

Bernstein (1999) is concerned with knowledge (discourses), which he describes as horizontal knowledge, which is everyday common sense knowledge in that it is “local, segmentally organised, context specific and dependent”. An example of this is the type of knowledge described earlier by Keane (2007) as ‘top of the head’ knowledge. Bernstein then describes vertical knowledge, which is one not based on everyday interpretation but based on formal education in which knowledge is extracted from everyday meanings in that it is “coherent, explicit and systemically principled structure”.

Vertical knowledge is then described as either having vertical or horizontal knowledge structures. Hierarchical knowledge structures (as found in natural science and medicine) “attempt to create very general propositions and theories” by integrating existing knowledge when constructing new knowledge.

Horizontal knowledge structures (as in the humanities) are composed of “a series of specialised languages, each with its own specialised modes of interrogation and specialised criteria”. The social sciences represent themselves as possessing segmented languages with some having stronger verticality (Bernstein, 2000: 159). Disciplines can be seen as having hierarchical or horizontal knowledge structures (Bernstein, 1999). Hierarchical knowledge structures build and integrate knowledge at lower levels in order to “create very general propositions and theories”. This involves an integration of existing knowledge and new knowledge by building generalised propositions. On the other hand horizontal knowledge structures can be viewed as “a series of specialised languages, each with its own specialised modes of interrogation and specialised criteria”. This type is found in the humanities whilst hierarchical knowledge structures are found in the natural sciences.

The potential of Bernstein’s insights will be described later in Engeström’s (1987; 2001b) model of expansive learning which involves workers moving horizontally between other systems and workers. This can involve contested dialogue between

workers holding a scientific knowledge and skill base with those expressing a contested 'everyday conceptualisations of activity such as non-clinical drug workers. For example, the aforementioned differences between those workers espousing a harm reduction policy of methadone maintenance versus those advocating a drug free lifestyle approach encapsulates the dichotomy and tensions which whilst appearing to be based on knowledge differences are often clouded by allegiances to belief systems. The challenge for this study is to use expansive learning to address such tensions. This can be assisted by the development of cognitive trails, which 'mark' the territory of person's experiences and actions over time, and which can lead to changes in practice (Cussins, 1992). "In such divided terrains, expansive learning needs to take shape as *renegotiation and reorganization of collaborative relations and practices between and within the activity systems involved*" (Engeström, 2001b:2).

3.3.2 Bernstein and power issues

Bernstein (2000:22) developed a model for displaying how the distribution of power and principles of control translate into pedagogic codes and their modalities. This demonstrated how these codes shape consciousness, reflect macro structures of power and control, and illuminate how order and change exist within these codes. "The model makes possible specific descriptions of the pedagogy process and their outcomes". Bernstein points out that the concepts of classification and framing should be treated as conceptually separate to pedagogic codes. "We need to know the processes whereby particular code modalities are constructed, institutionalised, distributed, challenged and changed". We need to know ". . . how does power and control translate into principles of communication, and how do these principles of communication differentially regulate forms of consciousness with respect to their reproduction and the possibilities for change". The SCP module as a specialised form of pedagogic code and "pedagogic culture" could provide this illumination (Bernstein, 2000:24).

"Code is a regulator of the relationships between contexts, and, through those relationships, a regulator of the relationships *within* contexts. What counts as a context depends not on the relationships within, but on the relationships between contexts. The latter relationships, *between*, create boundary markers whereby specific contexts are distinguished by their specialised meanings and realisations" (Bernstein, 2003:15). Some of these boundary markers can be exclusive to clinicians such as those concerning confidentiality relating to worker knowledge of patient blood borne disease status.

"It follows from the definition that, if code selects and integrates relevant meanings, then code presupposes a concept of irrelevant or illegitimate meanings: that, if codes selects form of realisation, then code presupposes a concept of inappropriate or illegitimate forms of realisation; that, if code regulates evoking contexts, then again this implies a concept of inappropriate, illegitimate contexts. The concept of code is inseparable from the concepts of legitimate and illegitimate communication, and thus it presupposes a hierarchy in forms of communication and their demarcation and

criteria (see appendix 1.1)." (Bernstein, 1990:15). The distributed expertise and knowledge of various workers portrays a wide range of codes.

3.3.3 The pedagogic device

Bernstein (1990, 2000) described the ordering and disordering capabilities of pedagogising knowledge as the pedagogic device. "He suggested that this device constituted the relay or ensemble of rules or procedures via which knowledge (intellectual, practical, expressive, official or local knowledge) is converted into pedagogic communication" (Singh, 2002:573). It is at this site that workers contest and attempt to control the production and distribution of different pedagogic models. In this section the pedagogic device is examined in terms of its conceptual structure which has an 'intrinsic grammar' which regulates pedagogic communication; and as a literal device which is embodied in the SCP as an arena for worker activity. "The pedagogic device acts as a symbolic regulator of consciousness; the question is, whose regulator, what consciousness and for whom? (Bernstein, 2000:37). This has great potential in terms of the reproduction of and changing knowledge within a virtual environment. Bernstein asks the question "are there any general principles underlying the transformation of knowledge into pedagogic communication, whether the knowledge is intellectual, practical, expressive, or official knowledge or local knowledge?" (Bernstein, 2000:25). The SCP as a pedagogic device allows the introduction of new forms of knowledge regulated by the structure and rules which although acting as a vehicle can determine the direction ('meaning potential') which that vehicle takes. In so doing it has the potential to change existing activity systems, with power and division of labour implications, as well as affecting consumer and agency cost benefits. It could be argued that the SCP recontextualises the existing pedagogic device (currently dominated by the medical and public health models) into one where rehabilitation is in the ascendancy. The latter ascendancy is influenced by holistic care planning, drug free goals for clients in care plans, and a developing rehabilitation philosophy based on a community development model and a social movement impetus.

Daniels (2008:152) identifies the necessity to examine tool use from a theoretical and empirical point of view with an analysis of its production within the context of social practice. He points out that "... the crucial issue is the translation of power and control into principles of communication which become (successful or otherwise) their carriers or relays." Therefore, according to Bernstein (2000:91):

"Explicit rules are required for: writing these principles of communication, their social construction and institutional bases; their modalities of transmission and acquisition as pedagogic discourse and their institutional bases; identifying the various realisations of members of groups/classes and agencies as cultural displays of a specialised consciousness."

The use of the SCP module can be viewed as a pedagogic device in which a specialised form of code introduces a new tool and framework for multidisciplinary working. In practical terms the SCP is a specifically designed framework which consists of SMART (specific, measurable, achievable, relevant and time-related) concepts in which the needs of clients are identified and matched to appropriate

treatment and rehabilitation interventions. It also contains a BOSS (build on social supports) structure. The SCP tool can be viewed both as a means of disrupting existing practice and as a means of facilitating new forms of practice. The SCP can be seen as an example of the 4th principle of AT in that it is a new element which disrupts or acts as a secondary contradiction (Engeström et al., 1999).

Daniels (2008:155) points out that “In Engeström's (1996a) work with activity theory, the production of the outcome is discussed but *not the production of the tool itself* . . . The production of the cultural artefact, the discourse is not discussed, is not analysed in terms of the context of its production, that is the rules, community and division of labour that regulate the activity in which subjects are positioned”. The role of the agents who might control the pedagogic device (SCP) and the associated discourses, texts and relations between workers exercises real control and power in terms of rule creation and determining who is allowed to do what, with whom and to whom. Essentially this raises the questions such as:

“Who says I have to work in this particular way and with these other workers?”
“So who is going to say we do this?”

It is at these points of classification (and possible resistance to tool acceptance) where strength of insulation between workers is evident. Accordingly, tension, contradiction and power concerns are evident and it is those expressions that DWR uses in its attempts to positively transform practice. This is especially so regarding boundary crossing efforts as it embodies Bernstein's references to power relations establishing defined relations of order by addressing issues concerning boundaries (Engeström 2001:4; Edwards et al., 2009:146; Daniels, 2008:170). Accordingly, the use of the SCP module as a pedagogic device is evident in the way in which activities between individual workers are regulated in the way described by Bernstein.

This has implications for the continued development of distributive expertise in terms of recontextualisation and pedagogic discourse. Distributed expertise is not a stable knowledge structure as it can be reconstructed and transformed to learn, act in and transform problems of practice (Edwards et al., 2009:131). This can involve the questioning of existing practice as well as addressing contradictions, new aims, new strategies and new practices with likely changes to existing divisions of labour and appreciation of the roles and contribution of others. This may invoke signs of resistance to changing practice and strategy as this can involve changes to worker identity (Engeström, 1987).

The function of the SCP also meets 'official' organisational and policy objectives regarding cost/benefit efficiencies and better integrated working practices. The flexible framework of the SCP allows for a weakening of the knowledge and communication boundaries that currently separate occupational groups by improving collaboration as well as the cohesiveness and integration of service provision. Bernstein describes this in terms of a hierarchy of rules (distributive, recontextualising and evaluative) which are interrelated and subject to power relations. Distributive rules “regulate” the relationships between power, social groups, forms of consciousness and practice” which makes up the differing ways in

which meaning and pedagogic identities are formed (Bernstein 2000:28). Recontextualising rules serves to regulate the formation of particular pedagogic discourse. Therefore pedagogic discourse can be seen “. . . as a rule which embeds two discourses; a discourse of skills of various kinds and their relations to each other, and a discourse of social order. Pedagogic discourse embeds rules which creates skills of one kind or another and rules regulating their relationships to each other, and rules that create social order” (Bernstein, 2000:30).

Recontextualisation involves moving a discourse from its original location as a form of production to another where it has the potential to be altered in relation to other discourses because it has been converted into a pedagogic discourse. Evaluative rules are formed by specific pedagogic practices which are based on what is regarded as valid instructional and regulative content.

The collaborative use of the SCP module has the potential to move workers from fragmented demarcated working to one which via co-configuration meets the design and policy aims of the SCP design structure. The design implications for such a tool will not be considered here in depth but these can have arguable profound effects on working relationships (Nardi, 1996; 2005). Feenberg (1991) explores ontological critical concerns about the possible application of technology within modernity. He suggests that the use of technology is value laden but that it is also essentially subject to human control. This assumes that technology is a means of reproducing influence and power.

The SCP provides for the operation of official and unofficial discourse and the capacity of agents to fulfil roles within those contexts. A Bakhtinian view of these contexts will be discussed in the next section. Meanwhile, Bernstein (2000:56) importantly, distinguishes between an official recontextualising field (ORF) created and dominated by the state and its selected agents and a pedagogic recontextualising field (PRF) comprised such ideas as competence models and other pedagogies. An illustration of this can be seen in terms of state dominance over the practice of case management (Payne, 2000). Drawing on Bernstein's (2000:33) observation one could consider this as an example of the UK state attempting to weaken PRF through its ORF and thus reducing worker “relative autonomy over the construction of pedagogic discourse”.

The important point is that *regulative discourse produces the order of instructional discourse* which has implications for the construction and acceptance of protocols (clinical or rehabilitation based) written for the SCP module. For example, Payne (2000) observed that state intervention (ORF) could be seen as detrimental as it attempted to control resource use, and failed, in directing regulations concerning case management. It could be argued that in the absence of a recognised evidence-based knowledge, and ‘proper’ audit and governance structures in the rehabilitation sector, there is a possibility that clinical protocols will gain ascendancy in the SCP domain because of their perceived ‘superior’ reliance on a scientific evidence base which addresses quality standards and variance tracking.

Lastly, there is a requirement to consider one further appreciation of the function of the SCP, as a ‘voice’ constituted by the pedagogic device. “A more appropriate

metaphor may be that the pedagogic discourse device is a grammar for producing specialized messages, realizations, a grammar which regulates what it processes: a grammar which orders and positions and yet contains the potential of its own transformation" (Bernstein, 1990:190). "Through the notions of 'voice' and 'message' he brings the division of labour and principles of control (rules) into relation with social position in practice" (Daniels, 2008:163).

In defining a new form of practice via the use of the SCP tool, the distributed expertise of different workers (subjects) is collaboratively used in a wider multi-level form of pedagogic practice, with the potential to lead to concomitant communication changes (Daniels, 2008:153). It should therefore be possible in this context to examine the influence of the design concepts of the tool; the nature and production of the tool, as well as the use of the tool. This form of analysis utilises Bernstein's concept of 'social positioning' in order to understand the relations and dynamic between subjects, the subject's relations with the tool itself and the realisation of the objects of activity. There is therefore a potential for new practice to be based upon a new subject orientation which listens to a new legitimated shared language.

The use of DWR methodology could facilitate the development of a form of descriptive language which accommodates the prophesied weakening of boundary relations between subjects (Daniels, 2008:162). This could be articulated by creating a space for a separate voice which describes this new form of language and the creation of new identities. It is envisaged that the planned empirical project, through its facilitation of a new form of social positioning and the possibility for shaping new worker identity, could provide insights into and further the development of activity theory. For this to be possible, a shift would be required, from the fragmentation of occupational activity (and its associated control and power relations) which seeks to further serve the occupation itself, to one which is transparent, altruistically focused and based on social justice principles. Were this to occur, a new hybrid form of professional practice could be created which would have wider implications for collaboration in complex tasks. At this juncture it is important to note that the voice of the client is unlikely to be represented other than through one of the workers. The voice of the client and workers will be explored further in the next section.

3.3.4 Limitations of Bernstein's approach

Various criticisms have been made of Bernstein's work which has been progressively developed and revised over time. These criticisms have been ably addressed by Bernstein (2000) who has seen some of this early work simplistically represented or criticised by those concerned with writing text books as opposed to empirical efforts to address his work which attempts to connect micro processes of human activity to structural concerns with power. Sadovniki (2001:5) in an obituary of Basil Bernstein noted that "Karabel and Halsey argued that one of the most unresolved problems of Bernstein's work is how 'power relationships penetrate the organization, distribution and evaluation of knowledge through the social context' (cited Karabel & Halsey, 1977:71)".

It could be argued that social structures provide resources that enable individuals to act, as well as placing limits on individual behaviour. Bernstein (2000:164) does raise issues concerning the management of horizontal knowledge structures due to the range of languages which have to be managed and this has implications for the range of non-clinicians many of whom have lower levels of skills and knowledge (those with a less explicit conceptual syntax and weaker grammars) than others, such as clinicians, possess. This, in some cases causes problems in acquirer interpretation as non-clinicians may be reliant on a “gaze” which allows them to recognise and consider the legitimate phenomenon even though they “rarely have access to the transmitter(s) recontextualising principle” (Bernstein, 2000:173). This has implications for clinicians and non-clinicians working together. For example, whether there is a possibility for convergence similar to that which occurred between social and psychological sciences. In other words can the specialised discourse of clinicians be transformed from a specialised discourse to one which is pedagogised to allow communication with non-clinical workers? This assumes that non-clinicians will engage in a way that does not shun intellectual effort. The theoretical possibility for such convergence exists as “the theory of instruction selects both the ‘what’ of the specialised discourse and the modality of its realisation. It guides the recontextualisation process” (Bernstein, 2000:173). The pedagogic recontextualising field is an area of conflict and struggle over dominance which functions at organisational, actor and identity levels (Bernstein, 2000:62). Although, the dominance of recontextualising fields in terms of ORF and PRF as well as the introductions of new discourses are critically important for the actors with new motivations in such an area (Bernstein, 2000:61). However, while it has been stated that the “the acquirer rarely has access to the transmitter(s) recontextualising principle” . . . “this principle is tacitly transmitted and is invisibly active in the acquirer as his/her ‘gaze’ which enables the acquirer metaphorically to look at (recognise) and regard, and evaluate (realise) the phenomena of legitimate concern” (Bernstein, 2000:173).

Wheelahan (2006:8) also notes this aspect of Bernstein (2000:166-169) about “knowledge being defined by the knower rather than coming up with a language of description that practically defines the object under study. . .” Wheelahan argues that “Bernstein’s approach is underdeveloped, because he argues that the phenomenon being studied is “irrelevant to the question of status of knowledge” (Bernstein, 2000:166). The object of study recedes in importance, because the structure and grammar of the discourse is more important”. An interesting footnote points us to Moore and Maton (2002) who state that Bernstein has described but not explained the generative principles to further explore the aforementioned differences between workers who use relativist theories of knowledge to the less dominant workers who generate theories of knowledge which are expressed through empirical languages of description. This goes some way in legitimising the efforts of some workers who do not possess clinical or recognised qualifications. This militates against the development of shared knowledge due to hegemony influences which can exclude the knowledge and role of other workers. Clinicians can be viewed as being part of a hierarchical knowledge structure which legitimates and generates knowledge with reference to the epistemic relationship between knowledge and the associated object. Within the SCP scenario clinicians are being invited to have communication with a wider range of workers with a relativist approach and other

perspectives of reality. Unfortunately, Bernstein “did not systematically analyse professions or the distinctive character of professional knowledge” but was concerned with marketisation and the dominance of state regulation concerning knowledge production and pedagogic transmissions (Beck and Young, 2005:184).

Bernstein also “says very little about changes in occupations, and the complex and varying relations that may exist in different professions between their ‘real world’ conditions of professional practice, the formal organisation of the profession as a collegiate body, and university-based teaching and assessment of the professional disciplines” (Beck and Young, 2005:192). Beck and Young (2005:194) also raise other interesting considerations such as the influence of audit cultures and intra-professional differences and tensions and the transformation of professionals into “bureau-professionals”. They acknowledge that Bernstein (2000) in chapter 9 had begun to address the notion of expertise.

In conclusion, the use of activity theory facilitates theoretically and empirically our understanding of the aforementioned processes by focusing on instability and tensions “as the motive force of change and development” (Engeström, 1999a). Such factors have not been fully developed in Bernstein’s analysis. Bernstein viewed different categories of workers as being subject to different forms of classification (boundary strength) and framing (control) in terms of their role and claim to knowledge and as being subject to power relations. However, whilst describing these differences and influences, this research will examine the functioning of workers through the process of how workers make sense of their pedagogic world “to understand dialogues and multiple perspectives on change within networks of interacting activity systems” (Daniels, 2008:164).

“In this way the model of division of labour, community and rules of Activity Theory is enhanced and refined in order to allow the production of the cultural artefact (the discourse) to be described in terms of the power relations, which create the categories of the context and the forms of control which regulates communication. The process of research using this approach involves the development of models which are themselves subject to transformation and development” (Daniels, 2004a:131).

This section has illustrated the value of a Bernsteinian approach in addressing some of the deficits within AT. The next section will appreciate the contribution of Bakhtin to this pluralistic process. In section 3.5 it will be shown that there are also similarities with a critical realism approach which is also congruent with a Bernsteinian analysis as critical realists have sought to transcend AT’s limited response to the interdependence of structure and agency.

3.4 Bakhtin

This section will explore the potential contribution of Bakhtin’s concept of social language and multi-voiced understanding of communication in order to extend an appreciation of the occurrences within the SCP arena. The similarities between Vygotsky and Bakhtin will be drawn in order to enhance understanding of multi-

voicedness as one of the five principles of activity theory. This focus on the use of social language, by individuals and groups, will explore the nature of multiple voices as both units of language and their connection to socio-institutional activity. Finally, the role of medicine will be examined as an insular discourse with a significant connection to authority. It is hoped that an exploration of Bakhtin together with the aforementioned Bernsteinian understanding can be developed to address multidisciplinary issues.

The SCP module has been identified as an arena in which existing tensions between workers are played out and where there is a possibility for developing new multidisciplinary practice. Will a generic voice and new language emerge or will the insular, demarcated voices of workers retain their one-voicedness? It is possible that a Bakhtinian perspective will assist in addressing wider issues concerning 'fragmentisation, demarcation of working practice and worker adherence to different models of conceptualising their modus operandi? In this way the dialogicity and historicity of discourse between perspectives and voices can be considered as it affects what an individual voice can say (Bakhtin, 1981:272,430).

"All words have the 'taste' of a profession . . . Each word tastes of the context and contexts in which it has lived its socially charged life; all words and forms are populated by intentions. Contextual overtones (generic, tenuous, individualistic) are inevitable in the word" (Bakhtin, 1981:293).

3.4.1 Similarities between Vygotsky and Bakhtin

Bakhtin's work has some similarity with Vygotsky in terms of the historical and social aspects of voices and how they are influenced by others (Bakhtin, 1986:92-93; Daniels, 2008:62). However, Bakhtin uses metaphors and assimilation whilst Vygotsky uses the word internalisation to describe the influence of others; although both see it as a transformative process from functional and ideological viewpoints respectively (Farmer, 1995:307). Bakhtin (1981:294, 276, 346) and Vygotsky (within the ZPD) view progress as movement towards forming a new state which involves addressing the needs of others and the incorporation of the notion of struggle.

"The important point is that at any given moment, the voice we choose to call our own is made possible by all those other voices that vie for hegemony in our consciousness, that form the chorus of voices against which 'are own' may eventually be heard" (Farmer, 1995:308) . . . "the internally persuasive word is half-ours and half-someone else's . . . and the boundaries between the two are at first scarcely perceptible " (Bakhtin, 1981:293,345).

Both Vygotsky and Bakhtin describe language in terms of interpersonal communication involving a social dimension. AT developments such as expansive learning and developing practice towards a ZPD goal is based on iterative learning as tensions and contradictions are addressed. For Bakhtin communication does not just involve interpersonal communication as it includes the dialogic functions of all communication. This is advantageous for increasing our understanding as it could make up for AT deficits by exploring concepts such as heteroglossia and voice. "Ritva Engeström (1995) has shown an interesting parallel between Bakhtin's concepts of social language, voice, and speech genre, on the one hand, and

Leont'ev's (1978) concepts of "activity, " "action," and "operation" on the other hand. Bakhtin's notion of social language corresponds to Leont'ev's concept of collective activity, or activity system. Just as an individual action is embedded in and realizes an historically evolving collective activity, the voice of a speaking subject always calls forth and reproduces a social language to produce an utterance" (Kärkkäinen, 1999:73).

Holland and Lave (2001:12) note that self authoring is common to both "Bakhtin's dialogic approach and Vygotsky's (1971, 1978a, 1978b, 1987) related perspective emphasize the importance of words and verbal genres as the media through which senses of self and group are developed".

"We conceive the space of authoring, then as a broad venue, where social languages meet, generically and accentually, semantically and indexically, freighted with valences of power, position and privilege. Such a large concept is needed if we are to develop notions of authorship, of social and personal agency, that do justice to both Vygotsky's keen sense of persons-in-history and to Bakhtin's heteroglossic (and, we might add, heteropraxic) social worlds. Such a concept is needed to do justice to the complexities of self-fashioning in every day worlds" (Holland et al., 2001).

Holland and Lave (2001:3-5) view agents addressing tensions as contested historical processes of social formation and cultural production in which disproportional resources across different social relations and perspectives are evident in the way in which identities are formed. Holland and Lave (2001:9) assist with an appreciation of Activity Theory and Bakhtin by pointing to four dialogic themes (dialogism, cultural genre and self authoring, boundaries and dialogism and generativity) which enable the conceptualisation of "... the interplay between the local historical formation of persons in practice and the (mediated) place of historical subjectivities in the creation and undoing of enduring struggles".

"In short, the self is an orchestration of the practices of others, but we do not relate to all such practices in the same way. This emphasis on problematic boundaries and varying stances provides a suitably nuanced appreciation of the possibilities that arise in local struggles" (Holland and Lave, 2001:15).

Such understandings are useful in considering dynamics within the SCP module as there is potential for heteroglossia and the erection and dissembling of boundaries between workers. This has potential for impacting upon identifications and social inscriptions applied to practice with others. Both Bakhtin and Bernstein view workers as dialogic selves engaging in practices and struggles, which are subject to power and privilege, yet having the potential to culturally generate and develop other ways of interacting in terms of practice and addressing institutions and thereby "furnishing a living edge to change".

"The creation and development of subjectivities, even those marginal to power, is made possible, even likely, because cultural forms are not only tools for positioning the other but also tools for positioning the self. They are a means of re-identifying self. ... Discourse theory's focus on subject positioning leads us to attend to the power of state and other hegemonic discourses and

cultural forms to objectify social position as behaviour, to inscribe state categories in the body's habits, and to make subjectivities of those they define" (Holland and Lave, 2001:20).

In concluding this subsection it can be seen that Bakhtin enhances an AT approach. Whilst AT focuses on development and human activities there is a need to utilise a Bakhtinian approach to consider political and rhetorical issues as well as a form of "synchretism" (attempted reconciliation).

"The most important development in this direction, although currently underdeveloped, is AT's adoption of Bakhtin's dialogism. . . . Engeström and his colleagues have started to use dialogism to characterise how activities interact without dialectical synthesis, although they do not draw a clean line between dialectics and dialogism. This seems to be a vital development if AT is going to address slicing, alliances, multiplicity and rhetoric in much detail" (Spinuzzi, 2008:206).

This comment refers to Engeström's (1999c) use of Bakhtin and the development of third generation activity theory. It also touches on issues of power, contradictions and struggles, which Daniels (2008:127) argues would benefit from a Bernsteinian understanding. Daniels cites an example from Engeström (1999c:136) in which a patient, rather than being subject to a traditional patient/doctor relationship (in a Friedson (1970) sense) can be collaboratively constructed as a longitudinal care plan or care trajectory.

3.4.2 Social language

Bakhtin's concept of social language (a discourse of a particular stratum of society) is important as it focuses on the historicity of discourse between multiple perspectives and voices (the speaking personalities, the speaking consciousnesses directed by volition) and can be attributed to the discourses of different types of workers at any particular time as it shapes what an individual voice can say. Historicity is one of AT's five orientating principles which informs the way in which activity systems are transformed over time including the objects, ideas and tools which shape this process.

"Such is the fleeting language of a day, of an epoch, a social group, a genre, a school and so forth. It is possible to give a concrete and detailed analysis of any utterance, once having exposed it as a contradiction-ridden, tension filled unity of two embattled tendencies in the life of language. The authentic environment of an utterance, the environment in which it lives and takes shape, is dialogised heteroglossia, anonymous and social as language, but simultaneously concrete, filled with specific content and accented as an individual utterance" (Bakhtin, 1981:272).

Utterance, as used by Bakhtin, refers to discourse and is imbued with resonance of the past and often the rhetorical genres for transmitting another's speech by way of "rhetorical double-voicedness".

Daniels (2001:64) notes Cazden's (1993:198) thoughts about the commonalities between Bakhtin and Vygotsky, by way of the possibility of the specific social activity (practice) being connected to speech, which could provide a unit of analysis which connects mind with social interaction by way of Bakhtin's concept of 'responsivity' or 'addressivity'.

"Social languages can be viewed as a connection between individual functioning and socio-institutional activity which is at one time cultural and historical. They are mediating artefacts. Clearly they must be analytically connected with the activity within which they arise. However, this activity may not always be physically present. Vygotsky's attempts at providing the theoretical account of the production of cultural artefacts within specific activities were somewhat underdeveloped. He did discuss the notion of 'internal social voice'" (Daniels, 2001:64).

Multidisciplinary dynamics within the SCP are likely to reflect current differential policy dynamics, particularly in relation to the long-term use of methadone maintenance where there can be areas of agreement and disagreement which can have an impact upon collaborative working and entrenchment in 'divided domains' (DCRAGA, 2008).

"Within the arena of almost every utterance an intense interaction and struggle between one's own and another's word is being waged, a process in which they oppose or dialogically interanimate [mutually support] each other. The utterance so conceived is a considerably more complex and dynamic organism than it appears when construed simply as a thing that articulates the intention of the person uttering it, which is to see the utterance as a direct, single-voiced vehicle for expression" (Bakhtin 1981: 354).

However, a Bakhtinian perspective is not able to contribute to Bernstein's analysis of power as it does not address power relations adequately although power differentials are touched on in terms of centripetal and centrifugal (at the centre - at the margins) inequality of some discourses; other than his description of temporary suspension of reality in a carnivalesque context (Bakhtin, 1984:122-124). In this context medicine benefits from being regarded as a form of seriousness which is strict and scientific with a powerful influence on literature and culture (ibid). However, an exploration of medically dominated discourse will not be opened for examination from this perspective. Similarly questions concerning the potential ascendancy of the rehabilitation perspective within the addiction domain will not be explored.

Voice

Bakhtin's concept of voice can be used to illuminate and analyse the discourses of others in the SCP, the multiplicity of views, and the historicity of activity and language. It can also illuminate the client perspective, although this is usually achieved through the voice of other workers. The direct client voice is one which is missing and therefore has low status and unequal representation. Bakhtin regards discourse (utterance) through the use of voice as being connected to the social context of language. However, attempts to understand the dialogic nature of language are fraught with complexity.

"The word in language is half someone else's. It becomes "one's own" only when the speaker populates it with his own intention, his own accent, when he

appropriates the word, adapting it to his own semantic and expressive intention. Prior to this moment of appropriation, the word does not exist in a neutral and impersonal language . . . but rather it exists in other people's mouths, in other people's contexts, serving other people's intentions: it is from there that one must take the word, and make it one's own Language is not a neutral medium that passes freely and easily into the private property of the speaker's intentions; it is populated- overpopulated- with the intentions of others. Expropriating it, forcing it to submit to one's own intentions and accents, is a difficult and complicated process" (Bakhtin, 1981:293-294).

On the other hand Bakhtin's position can be contrasted with Bernstein's concepts of voice and message which connects division of labour, rules, social position and practice.

"The implication is that subject in an activity theory driven depiction should be represented by a space of possibility (voice) in which a particular position (message) is taken up. It is also argued that multiple identities are developed within figured worlds and that these are 'historical developments, grown through continued participation in the positions defined by the social organization of those world's activity' (Holland et al., 1998:41). This body of work represents a significant development in our understanding of the concept of the 'subject' in activity theory". (Daniels, 2010:34).

Bernstein's use of 'voice' and 'message' illustrates how workers legitimate their use of language and claims to professional knowledge. Different occupational categories develop specialised voices which mutually impact upon the construction of the message. In practical ways different workers, operating out of different occupational silos, may undertake and make claims as to the legitimacy of their differing needs assessments and client care trajectories. However, the potential exists, through the use of mediation, to form an integrated care pathway (trajectory). In other words, whilst continuing to utilise occupation specific "voice" and "message," workers have the potential to collaborate, in order to establish new roles and practices.

Bakhtin, by selecting and using the voice of another, even though one can make it one's own in a different time frame, states that we undertake ventriloquism by using social language to express ourselves. Human activity is therefore multi-voiced and dialogical.

"Vygotsky saw the escape from the tyranny of environmental and internal stimuli as coming through the gift of collective symbols wielded toward the self. In Bakhtin, escape from being ventriloquated by first one and then another authoritative voice comes through the orchestration of and adoption of stances toward these voices, arrangements that are themselves suggested (perhaps) by texts" (Holland, 1998:185).

"All of each individual's words are divided into the categories of his own and others', but the boundaries between them can change, and a tense dialogic struggle takes place on the boundaries". (Bakhtin, 1986:143).

Prior (2001) identified three dimensions of dialogic voicing which he described as typified social voices imbued with social identities, the re-envoicing of the acts and

words of others, and a personalised voice in which learning and development is attained via a process of continuous development.

Prior refers to personalisation involving the processes of internalisation and externalisation which is akin to AT. Bakhtin views such a process as movement from an authoritarian discourse into a more persuasive discourse. This could be achieved by a process of learning within the context of the SCP module where more authoritarian or insular discourses can change within situated learning environments in which meaning and activity can be changed via collaborative efforts.

Bakhtin's utterance chain

An examination of the utterance chain is necessary as it relates to communication acts and units of activity within the SCP module as exemplified in the case example in Appendix 1. The development of the associated client progress notes module within the EPS allows for the day to day 'real time' recording of worker client contacts, in relation to the interventions each individual worker is having with a client, and can be viewed in terms of the continuous contacts between the client and an individual worker or chronologically between the client and all workers. Within such a context "Utterance is the topic of analysis when language is conceived a dialogue, the fundamental unit of investigation for anyone studying communication as opposed to language alone" (Holquist, 1990:60).

For Bakhtin (1986:92, 93) 'utterance' is the central unit of analysis (p.85), determined by a change in speaking subjects even scientific genres (p.91, p.75), which provides the link in the chain of previous utterances and the links which follow in the chain of speech communication. But, it does not just repeat the past as each is located within its own time frame (p.91).

"Each utterance must be regarded as a response to previous utterances of the given sphere . . . Each utterance, refutes, affirms, supplements, and relies on the others, presupposes them to be known, and somehow takes them into account . . . Therefore, each utterance is filled with various kinds of responsive reactions to other utterances of the given sphere of speech communication" (Bakhtin, 1986:91).

Speech communication is then based upon the utterance which is not a singular act that relates solely to the interlocutor's volition based on feeling, motives and thoughts but on a chain of utterances that is dialogically created from past and yet to be created utterance where meaning is never finalised (Bakhtin, 1986:76). A single utterance may be semantically finalised as a unit of speech but the opportunity to respond to it is not (Bakhtin, 1986:71, 76-78). Change in the finalisation of an utterance is characterised by the interlocutor having said or written all they wish to; with the interlocutor's volition and the requirement of the speech generic deciding the typical or generic form of that finalisation.

Utterances also have an interpersonal and answerability feature in that they can be in a conversational context within a SCP structure. These contexts can contain an appreciation of utterances before or after one is made and the answerability that is supposed or made by the addressee in the understanding that meaning is not fixed.

Utterances can relate to one particular point of view (Bakhtin, 1981:291-292). For example, if one of the workers in the SCP expresses a view which might create contradictions (tensions) within multidisciplinary working.

“Every concrete utterance of a speaking subject serves as a point where centrifugal (unofficial discourse) as well as centripetal (official discourse) forces are brought to bear. The processes of centralization and decentralization, of unification and disunification, intersect in the utterance, the utterance not only answers the requirements of its own language as an individualized embodiment of a speech act, but it answers the requirements of heteroglossia as well, it is in fact an active participant in speech diversity” (Bakhtin, 1981:272).

Utterances in relation to official and persuasive discourse will not be discussed further although it has an interesting connection with the care and control dichotomy which is at the centre of personal services provision. It also has Bernsteinian implications in terms of power and its regulation.

Heteroglossia and polyphony

This section will comment on Bakhtin’s notion of heteroglossia and polyphony in relation to the multidisciplinary (multi-voiced) construction of an individual care plan and associated care trajectory in the SCP module. Bakhtin’s focus on language is important because for him it addresses context, it is multi-voiced and is subject to dynamic communication. In this way multiple dialogues constitute an act of communication which is formed by several voices which are not merged into a single voice but have their own larynx but yet can “sing” their own “melodies” within the context of the discourse.

Bakhtin describes the concepts of heteroglossia and polyphony as forming an act of communication which reflects the different backgrounds and social vagaries of individuals and groups.

“Heteroglossia is a situation, the situation of a subject surrounded by the myriad responses he or she might make at any particular point, but any one of which must be framed in a specific discourse selected from the teeming thousands available. Heteroglossia is a way of conceiving the world as made up of a roiling mass of languages, each of which has its own distinct formal markers. . . The idea of heteroglossia comes as close to conceptualising a locus where the great centripetal and centrifugal forces that shape discourse can meaningfully come together” (Holquist, 1990:69-70).

“Therefore it is not enough merely to uncover the multiplicity of languages in a cultural world or the speech diversity within a particular national language-we must see through to the heart of this revolution, to all the consequences flowing from it, possibly only under very specific socio-historical conditions” (Bakhtin, 1981:367).

Therefore according to Bakhtin (1981:272) every utterance from diverse groups involves centrifugal and centripetal forces answering each other and the unitary language as well as the social and historical heteroglossia of the other social groups. The multiplicity of languages is referred to as ‘polyphony’. Bakhtin’s (1981:367-368) use of polyphony refers to the multiplicity of languages which are unified and

managed by a particular organising principle known as “the universum of mutually illuminating languages”. This is subject to a unitary organising principle which results in the formation of many languages.

“Such a perception is possible only for a consciousness organically participating in the universum of mutually illuminating languages. What is wanted for this to happen is a fundamental intersecting of languages in a single given consciousness, one that participates equally in several languages” (Bakhtin, 1981: 367-8).

For polyphony to be maintained there needs to be a balance between the centrifugal forces of heteroglossia and the centripetal force of a single consciousness. The arena of the SCP provides for the aforementioned possibilities regarding individual worker language use and accordingly the possibility of translating such efforts into new practice.

3.4.3 Medicine as an insular discourse

It is arguable that medicine is an insular discourse or a single-voiced discourse which shuns dialogue from other discourses which are often seen to occupy auxiliary positions. This attitude, which is traditionally cultivated in the medical learning process may seem to be problematic in terms of Bakhtin’s concentration on double voiced discourse and ‘addressing ‘the words of others. Although it has been argued that “a voice in isolation has no reason to speak, no motive to be heard, and thus is meaningless” (Farmer, 1995:310).

In this context medicine can be seen as a unitary language which is opposed to the realities of heteroglossia, in the sense described by Bakhtin (1981:270), as it seeks to dominate all discourses through its use of its special argot in non-commonsense ways. In this way medicine can be conceived of as a single-voiced discourse as opposed to a double-voiced discourse (Bakhtin and Emerson, 1984) in that there is a perceived dominance of a single perspective.

“The degree to which a word may be conjoined with authority-whether the authority is recognized by us or not- is what determines its specific demarcation and individuation in discourse; it requires a distance vis-à-vis itself (this distance may be valorised as positive or negative, just as our attitude toward it may be sympathetic or hostile). Authoritative discourse may organize around itself great masses of other types of discourses (which interpret it, praise it, apply it in various ways), but the authoritative discourse itself does not merge with these (By means of say, gradual transitions); it remains sharply demarcated, compact and inert: it demands, so to speak, not only quotation marks, but a demarcation more magisterial, a special script, for instance. It is considerably more difficult to incorporate semantic changes into such a discourse, even with the help of framing context: its semantic structure is static and dead, for it is fully complete, it has but a single meaning, the letter is fully sufficient to the sense and calcifies it” (Bakhtin, 1981:343).

“Monologic, single-voiced discourse is discourse that recognizes only itself and its object, discourse that does not recognize other people’s words (*Problems* 185-87). Such discourse “is directed toward its referential object and constitutes the ultimate

semantic authority within the limits of a given context" (189). Dialogic, double-voiced discourse is discourse that contains a deliberate reference to someone else's words (185-87). Such discourse inserts "a new semantic intention into a discourse which already has, and which retains, an intention of its own" (189). Moran and Ballif, (2000). "A word, directed toward its referential object, clashes with another's word within the very object itself" (Bakhtin, 1984:195).

In conclusion, the role and influence of medicalisation was considered in section 2.5 as a dominant discourse which has changed in relation to other dominant paradigms over time. It could be argued that the medical profession monitors and protects its own authority but does not enter into dialogue with non-clinical efforts to address drug misuse in a mutually productive way. Indeed, medical perspectives which view other workers as 'ancillary workers' attempt to finalise meaning by way of its authoritative single-voicedness. Bakhtin would rail against such a process as it attempts to finalise meaning when it should remain open and subject to change in the dialogical evolution of meaning with others. Whilst medicine can be perceived as a single voiced discourse which serves to silence other discourses the adoption of a double-voiced discourse would allow for the dialogic interaction of other equally valued discourses and address the aforementioned inequality where one discourse is centred whilst another is given a peripheral status (Bakhtin, 1984:185). Accordingly, it would appear necessary to pursue the possibility of a multivoiced discourse that will recognise the legitimate efforts of all workers.

3.5 Critical Realism

This section reflects upon the multiple realities mentioned in the introduction section of chapter 2. Critical Realism (Bhaskar, 1978) attempts to account for the unknowns which have an impact upon the knowledge and awareness of workers engaged in shared care planning. Workers may be constrained by the limitations of knowledge contained within their own occupational fields and propensities to engage in insular discourse or the self imposed desire to function in terms of "a top of the head approach" described by Keane (HRB, 2007). This section contends that Critical Realism (CR) provides necessary theoretical underlabouring (Sayer, 2000) for this research project because it is able to consider structural concerns and the possibility of relating scientific and social science worlds that are absent in the aforementioned theoretical approaches.

Critical Realism "is an ontological theory which argues for the appreciation of experimental, actual and real levels of dimensions of reality. It emphasises the abstraction and conceptualisation of complex concrete phenomena, which encompasses all these realms, in order to facilitate the research for a feasible causal explanation. In doing so it argues that social and natural life are complex, structured and open, and we must sort out the contingent from the necessary relations influencing phenomena in order to progress causal explanation" (Lawson, 2006:262).

Support for the adoption of a CR approach is made by Wainwright (2008:14) in that it "... entails an engagement with the scientific content of a discourse, but also a sociological critique of the political, economic and cultural factors that determine the

form taken by a particular discourse at a specific point in time". In this way, and Wainwright provides examples, CR can "... extend the rigour by revealing the social and cultural aspects of scientific discourse. The goal of this approach is to aid the development of critical consciousness, which synthesises the insights of scientific enquiry, with an awareness of the different ways in which scientific knowledge can be interpreted and be applied to the resolution of problems and the fulfilment of human potential" (Wainwright, 2008:14). This is important as AT's practice emphasis on activity within its own bubble of multidisciplinary activity must not eschew formal and codified knowledge in the way described by Bernstein. For example, methadone maintenance treatment comprises of substitution treatment and the provision of psychosocial interventions (Dole and Nyswander, 1965). Whilst the latter element may not enjoy the recognition that it deserves; efforts to include both elements are recognised in national policy and in the funding of services contributing to treatment and rehabilitation solutions. These elements are therefore overlapping domains of experience with events that could benefit from appreciating necessary contingent relations which fit into the CR ontology.

Chapter 1 outlined the different interpretations of drug misuse, their implications for policy and practice and the fact that they are also subject to the scientific reality of pathological mechanisms which impact upon the management of the drug user. In this research context it involves a two way process of communication and activity between clinicians and non-clinicians with the latter only partially appreciating issues which are solely within the knowledge and skill domain of clinicians. Arguably it also behoves clinicians to engage with other workers. CR has the potential to appreciate the realities of both scientific and everyday worlds.

CR contends that there are three levels of reality: firstly, the empirical, which comprises experienced events; secondly, the actual, which consists of all events, irrespective of whether experienced or not; and thirdly, and most importantly, the causal, consisting of generative mechanisms (Houston, 2010:75). CR is an ontology that appreciates that there is more to view than that which is directly observable or experienced by individual actors or others. "Critical realism promotes the consideration of underlying social relations and causal mechanisms generating social practices, ideological constructs and perceived phenomenon" (Lawson, 2006:17). "However, realism contends that causal mechanisms can comprise not only practices and meanings but also social relations; together these overlapping domains of reality can shape social phenomena. Ideology and institutionalised social practices are important, but alone merely represent the locally mediated expression of underlying networks of social relations" (Lawson, 2006:21). The generative mechanisms developed and recorded in the CL sessions can be seen in CR terms as "tendencies" which allow for abstraction, abduction and retroduction" as defined later on in this section (Lawson, 2006:262).

Table 6: Comparison of AT and CR approaches

AT	CR
Allows for internalisation	Allows for Internalisation
Allows for externalisation	Allows for externalisation
Provides over socialised portrayal of man	Provides under socialised portrayal of man
Does not consider intrapersonal perspective	
Only considers learning occurring in the activity system	Considers learning outside activity system
Does not consider the holistic development of the individual	Examines individual's meanings, reasons, intentions and motivations
Does not explain how individuals are transformed	Provides a wider range of transformation possibilities.
Privileging learning	Uses contrastive and counterfactual questioning
Transformation of agency	Transformation of agency in conjunction with structural influences
AT gives insufficient attention to underlying theories of knowledge	Has potential for under labouring
AT, due to its failure to consider the individual, does not consider the needs of an individual who operate across "natural, practical and social domains simultaneously" (Archer, 2000)	Considers activities in both scientific and social domains
Agency can be transformed by privileging the social	Agency can be transformed by rationally engaging irreducible components

Wheelahan (2006:5) observes that whilst critical realism employs the notion of 'emergence', which is not a concept in activity theory, it is a useful to consider its potential to "analyse the interaction between the different components in the activity system".

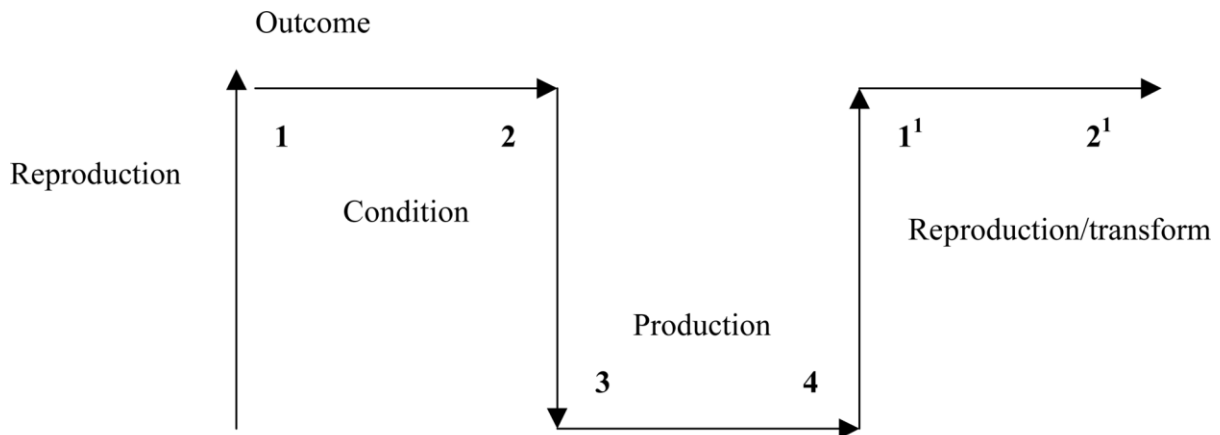
Connelly (2000:265) assists us in describing the transformational model of social activity:

"In an attempt to extend realism into social science Bhaskar is immediately faced with ``the vexatious fact of the social world" (Archer, 1995); the social world, unlike the laboratory experiment, cannot even in principle be ``closed" it is an irreducibly open system where explanation and understanding are more or less possible, but law-like prediction is impossible (Bhaskar, 1989a; Macintyre, 1985). What is, then, the ``object" of study within a naturalised social science? It cannot be, surely, an unchanging object, because social reality is fundamentally changing as well as static; it cannot be a non-human object, as social reality (unlike reality itself) must rely on human agency and activity to create it, sustain it and to transform it. Bhaskar's answer is that the object of an adequate social science is social relationships, conceived as relationships between agent and structure and between agent and agent. Through studying social relationships we may discover generative mechanisms which give rise (through their expressed or unexpressed causal

powers and tendencies) to the patterns of observations that we live with, use and change. The totality of these observations and our activities in generating them, using and changing them is our social reality (Bhaskar, 1989a)".

Generative mechanisms can be germ cells but all germ cells are generative mechanisms. Daniels (2008:109) points to possibilities of appreciating different knowledge structures in this context and in terms described by Vygotsky as the scientific and everyday worlds. This, according to Daniels (ibid.) was developed by Davydov and later by Hedegaard who believed that the teaching of theoretical knowledge should be the main aim rather than on teaching empirical concepts.

Connelly (2000:267) draws our attention "via (Bhaskar, 1978; 1989a; Archer, 1995) (Figure 1, stages 1,3,11)" to the role of agents in pursuing motives in terms of social activities which can sustain or change social structures as well as the opportunities open to them as "a function of agent-structure and agent-agent relations that constitute a life".



- Key: 1,2,3,4,1' are stages in Agent-Structure Interaction
- Stage 1: Initial socialisation in initial situation
 - Stage 2: Agent Self-Awareness of Situation
 - Stage 3: Agent Activity on and within Structure
 - Stage 4: Agent Activity to Explain (Reproduction) or Transform Situation
 - Stage 1': Agent Activity to Explain (Reproduction) or Transform Situation
 - Stage 2': New Awareness of New Situation (and so on)

Figure 4: The elaborated model of structure and praxis elaborated TMSA
(Transformational Model of Social Activity, Bhaskar, 1989).

Connelly sees the potential of CR to address difficulties in health care management but limits his scope by referring to case examples and 'what works, where and when' solutions. A critical realist appreciation of medical pluralism can extend our understanding of structural and individual explanations of the role of clients as they

are managed within a medically dominated or highly medically influenced domain. It can also allow us to appreciate and develop the historical and cultural understandings (more than a class-based interpretation of the medical profession) within a contemporary structure which can facilitate medical pluralism and a greater actualising role for the client. To be specific a critical realism epistemology which reflects naturalism, provides for the linking between natural and social science methods. In the context of this research it allows for the exploration of synergies between primary care, mental health and addiction sectors. It has the potential to address some of the perceived negative aspects of clinicians and treatment (long-term methadone maintenance) and to consider the potential of rehabilitation efforts and a more pluralist approach to the long-term management of clients and the realisation of a drug-free lifestyle option for more clients.

Critical realism provides for a dialogue between these sectors (clinical and non-clinical) by illuminating the association between observable reality and the generative mechanisms of social phenomenon, and how they may be understood, without adopting a conflict approach. AT combined with a Bernsteinian analysis allows us to explore agency and structural levels of analysis. A critical realism perspective still allows us to view these levels of analysis as being distinct and also allows us to historically view and contemporaneously explore possibilities for change in current medical systems. In this way, to examine interplay, reproduction, change or the emergence of new properties and powers over time and the potential for influencing structural change (Williams, 1999:798,808,809).

“There are resonances between the way critical realism and activity theory use abstraction and description to analyse society, and the way both seek to identify *underlying casual mechanisms* rather than restricting our theorising of the world to that which we can see and experience. Moreover, both reject the positivist search for prediction, which is grounded in an atomistic understanding of the social world and is based on the search for constant conjunctions of events, rather than a relational analysis of causal relationships (Sayer, 2000;Tolman,1999)” (Wheelahan, 2007:9).

In conclusion, Critical Realism provides for reductive (abductive) reasoning in order to explain why events occur. This is an important strand in this study’s theoretical multi-strand bow as it provides for the consideration of another perspective when considering generative mechanisms. Hammersley’s (2009) criticism of CR is that it is not in a position to draw value conclusions from factual evidence as this requires practical situated argument. This research goes some way to providing an empirical analysis. The use of CR allows an appreciation of the structure agency debate by considering the political dimension despite Hammersley’s concern about this. However, one is still left with concerns about what is real outside the bubble of the worker participants’ world in this research although their activity has been interpreted within the official world of Irish national drug policy apparatus and its gatekeepers’ willingness to promote effective change. This is despite different worker representation of the scientific and ‘everyday’ worlds. Interestingly, McEvoy (2003:416) similarly draws upon Payne’s (2000) analysis of case management (See Section 2.7.2) with Harrison Wood’s (1999) analysis of health service policy to illuminate how the identification of generative mechanisms can aid greater insight into policy evaluation. Four critical factors were identified to counteract the simplistic

view of policy makers which were based on ascribing management failure and professional resistance of professional groups rather than focusing on “. . . the character of the innovation; economic, political and social context in which it is introduced; the political interests of the stake holders; and political process of introducing the innovation”. Lawson (2006:262) assists with the necessary reasoning processes in this area by noting and defining the following basis for undertaking a critical realist analysis:

“Abstraction – If reality is complex, as realists suggest it is, research phenomena can be better understood by taking away single dimensions or components to identify and conceptualise causal processes between them. What dimensions should be examined in your research phenomena? How do these dimensions necessarily relate to each other and what are the possible, but unpredictable contingent relations?”

Abduction – This thinking process involves the interpretation and recontextualisation of the phenomena under research, using a plausible, justifiable set of explanatory ideas and concepts. This new interpretation is known as a postulate, or hypothetical conceptual model, which is developed in thought, in order to produce a new explanation of what is actually going on.

“Retroduction – This thinking process follows that of abduction. It tests the initial postulated description or explanation, using methods such as contrastive counterfactual questioning. Does the model adequately explain what is going on? Does it provide the most competitive explanation?”

3.6 Conclusion

This chapter has examined and emphasised the importance of considering several theories to appreciate the circumstances in which the field research will be employed and by so doing increases our understanding of multidisciplinary working in the shared care plan arena. Current practice has been characterised as competitive, fragmented, demarcated and subject to different models of care and is therefore a weak form of regulative practice. It has been suggested that the SCP tool weakens existing classification and framing across the multidisciplinary sector and as such has an affect on the recognition of values, democracy and social justice issues. A position that is congruent with Bernstein’s view of the world. The SCP tool therefore has the potential to create a disruption of old practice and by so doing facilitates the formation of new practice which can be determined by workers adopting a co-configuration approach to appreciate the voices of each other by recontextualising pedagogic discourse and pedagogic practice. An expansive learning approach facilitates this process particularly when it is combined with an appreciation of the multivoiced social languages, historicity, and knowledge and skill differences between workers as *“all the conflicting and complementary voices of various groups and strata in the activity system under scrutiny shall be involved and utilized”* (Engeström, 1987:315-316).

It can also be recognised, by adopting a critical realism approach, that generative mechanisms uncovered within specific social realities within the situational context of CLs can be further analysed. These illuminations may point to distributions of power and division of labour as well as the possibility of identifying metaphors of interpretation which direct ideology. "In sum critical realists endeavour to provide empirically feasible and competitive explanations for phenomenon of social relevance and concern" (Lawson, 2006:7).

Chapter 4 Methodology

4.1 Introduction

Chapter 1 justifies the use of AT, defines the problems facing addiction services and specifically defines the research questions, aims and objectives of this research. Chapter 3 outlines the development of associated theory and the five principles of AT. This methodology draws on the aforementioned understandings and provides the fieldwork structures and interventions to enable a group of multidisciplinary workers to identify the contradictions in their domain. This will then enable workers to develop their existing practice, via the use of a SCP tool and expansive learning, to identify that learning process and to appreciate the interpersonal and organisational practice and dynamics associated with that learning (RQs). This effort will be understood within a health, as opposed to its usual educational, context.

This chapter will describe the features of Developmental Work Research (DWR) and justify its use in terms of theory building and as a change agent activity. It will similarly describe the features of expansive learning and undertake a critique of this approach. It will describe the participants and the context in which they work. It will locate the participants working lives in relation to theoretical concepts within the DWR domain and suggest that they display some evidence of collaborative and co-configured working. The field work preparation, use of a change laboratory intervention and the use of D-analysis will be described. This fieldwork strategy and its deployment will form the basis for analysis. Such an approach within the health domain is an attempt to theoretically and empirically devise a system which can be replicated. This reflects the essence of the DWR approach which is to contribute to and develop greater understanding in this embryonic and relatively unknown academic area.

4.2 Expansive learning

The process of expansive learning (Engeström, 1987) assists the transformation process in moving from one state of social practice and organisational structure to another and as such reflects the movement from idea generation to translating that idea through innovation and a process of learning and diffusion of knowledge. This involves the expansion of the object that is being worked upon, which in this case is the construction of a shared object in relation to a client care trajectory. DWR and the change laboratory sessions are essential for the necessary process of expansive learning as participants question existing and historical practice, react to identified contradictions, and model new forms of practice (Engeström, 1999a; Engeström, 2007b).

The fundamental cyclical model of expansive learning is illustrated in Figure 5.

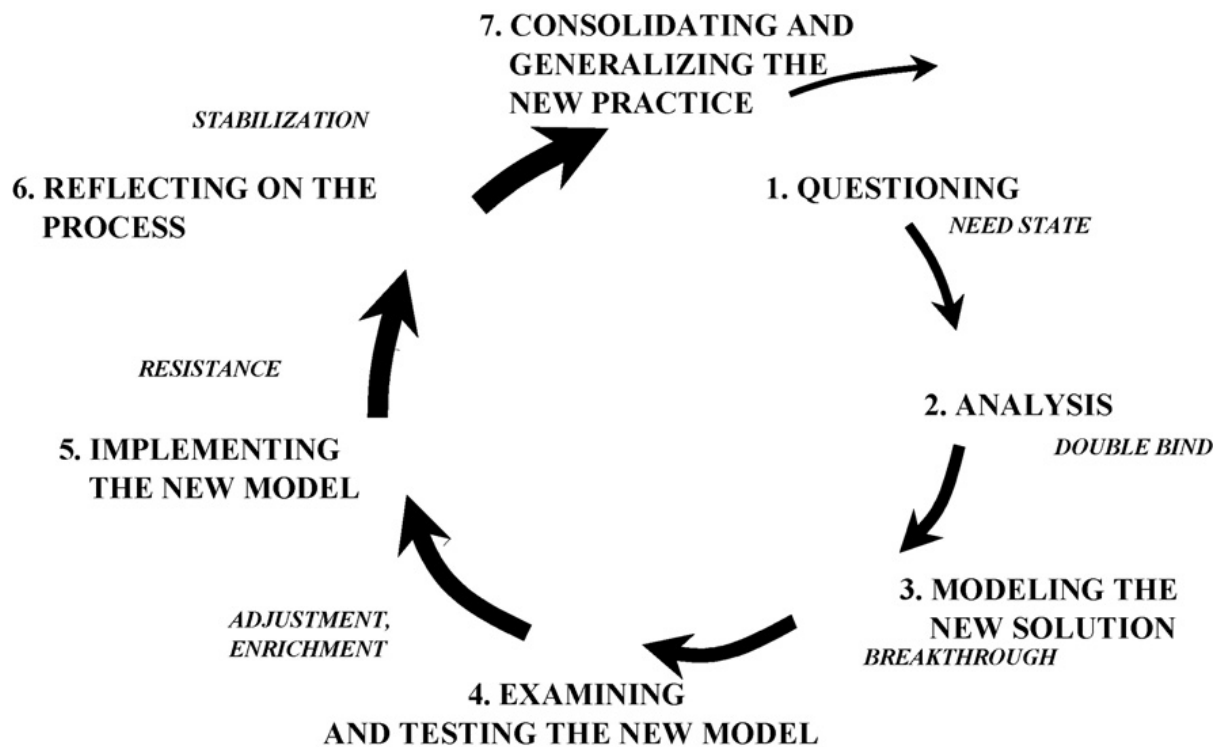


Figure 5: Sequence of learning actions in an expansive learning cycle (Engeström, 1999b:384)

The expansive learning cycle is important for the continuation of co-configuration work such as the work to develop distributed expertise by working towards the development of the SCP and its use to construct client care trajectories. Edwards et al. (2009) commented that “Finally, for us, as CHAT researchers, an added attraction of the Victor and Boynton model is its focus on how changes in conceptual tools, that is knowledge in use, are intertwined with changes in individual practices and in the services and systems in which they are produced.”

Co-configuration work (Victor and Boynton, 1998) has been depicted as having three central tenets by Engeström (2004).

“Expansive learning required and generated by the introduction of co-configuration work may be characterized with the help of four central features:

1. It is *transformative* learning that radically broadens the shared objects of work by means of explicitly objectified and articulated novel tools, models, and concepts that tend to form integrated multilevel instrumentalities or constellations.
2. It is learning by *experiencing* that puts the participants into imagined, simulated, and real situations that require personal engagement in actions with material objects and artefacts (including other human beings) that follow the logic of an anticipated or designed future model of the activity.

3. It is *horizontal* and dialogical learning that creates knowledge and transforms the activity, by crossing boundaries and tying knots between activity systems.
4. It is *subterranean* learning that blazes cognitive trails that are embodied and lived but unnoticeable. These trails serve as anchors and stabilizing networks that secure the viability and sustainability of the new concepts, models, and tools, thus making the multi-activity terrains knowable and liveable.

At this point, learning by experiencing is only a tentative proposition meant to stimulate further theoretical work and empirical studies.” (Engeström, 2007b).

Young (2001) raises some points for consideration in that learning may only be an incidental organisational goal whereas cost reduction is the primary one. Also, such learning may only be acceptable as long as it does not challenge the existing power interest of the organisation.

Engeström (2004:6 cited in Warmington et al., 2004:31) insists that it is essential to understand the object of work as a trajectory and to differentiate it from objects and goals. Warmington refers to Puonti (2004:34) “It is a moving target”. In healthcare, the object of activity is not based solely on pathology but by the dynamic transformation of the issues that entail when attempts are made to resolve them (Engeström et al., 2003:3). “Being solvable does not imply that the patient’s problem is relieved but characterises the object of clinical work as a trajectory from symptoms to treatment outcomes constructed with historically changing resources and distributed expertise” (Engeström, 2003:3).

Expansion of the object is associated with learning and has been depicted by Engeström in his model of expansive learning which provides for the introduction of tensions and concerns regarding the existing division of labour and power forces which challenge existing perceptions of practice. Expansive learning, according to Daniels (2008) is learning something that has not been developed, particularly as a result of policy edicts. Learning involves boundary crossing between practice and organizational boundaries and might include features of knotworking. Learning will also involve appreciation of different notions of knowledge, skill and status which has been described by Engeström et al. (1995), as a change from a vertical stabilized view to a horizontal view which enables negotiation and dialogical problem solving and boundary crossing.

4.2.1 Critiques of expansive learning

Critiques of expansive learning have been examined by Engeström and Sannino (2010) who divided them into three categories. Namely, those who see associations between their own research interests on learning and those “. . . who take a strong Marxist or dialectical stance and criticize the theory of expansive learning for misguided or conservative dilution of the Marxist and dialectical legacy (Avis, 2007; Langemeyer, 2006)” (Engeström and Sannino, 2010:16). Interestingly, they also refer to criticism of Lompscher (2004:388) who notes the absence of not relating expansive learning to cultural changes induced by IT developments.

Spinuzzi (2008:187) believes that Engeström and his fellow theorists have unnecessarily complicated their model of expansive learning by introducing the idea of 'multidimensionability' in which "experts are viewed as operating in, and move between, multiple, parallel activity contexts. These multiple contexts demand and afford different, complementary but also conflicting cognitive tools, rules and patterns of social interaction. Criteria of expert knowledge and skill are different in the various contexts. Experts face the challenge of negotiating and combining ingredients from different contexts to achieve hybrid solutions. The vertical master-novice relationship, and with it in some cases the professional monopoly on expertise, is problematised as demands for more dialogical problem solving increase" (Spinuzzi, 2008:3).

"In Engeström's view, activities can co-exist without merging or synthesizing. In fact, Engeström and his colleagues working in this strand of activity theory have increasingly used Bakhtin's concept of *dialogue* to talk about how activities can interface, and how people within those activities can cross boundaries, without the activities synthesizing and transforming into higher forms, as one would expect in a strictly dialectical model (Engeström, 1999, 2004). The boundaries that workers cross, the overlapping activities in which they work, constitute the polycontextuality discussed in this strand of activity theory (cf. Engeström, Engeström & Kärkkäinen, 2005) and result in multivoicedness (Engeström, 2001) or polyvocality (Tuomi-Gröhn, 2003; Tuomi-Gröhn et al., 2003) at every level. Polycontextuality and boundary crossing are iteratively connected (Engeström et al., 1995), then, with the overlapping of activities generating new contexts" (Spinuzzi, 2008:188).

Engeström and Sannino (2010) do refer to Kerosuo (2006) who undertook research into chronic illness which included the development of a care plan to address fragmentation of care between primary and secondary health services. Unfortunately, despite much effort, the care plan failed to be accepted into working practice. Engeström and Sannino (2010:17) also noted that "Computerization of medical records may offer new possibilities for implementing co-configuration – but it can also be used as an excuse to avoid or postpone such deep changes in collaboration and division of labor."

In conclusion, Engeström and Sannino (2010) stress the importance of participants influencing their own activity systems and their development of new forms of agency (an individual(s) capacity to change the world by their own behaviour) via concept formation and co-configuration. One is reminded that there is an erosion of the potential of agency to address the threats of modern society whether there are economic, policy changes radically overhauling service provision and regulation; let alone those that result in mental and physical anxieties (Wainwright, 2008:191). "There is a new culture of fear, vulnerability and uncertainty that threatens to undermine medical progress. These changes have sociological origins, and it is only by exploring those origins and bringing them into public consciousness that the prevailing anti-humanism can be challenged" (Wainwright, 2008:193). Therefore, efforts to promote the potential of agency and transformation of society deserve effort and encouragement.

“People and organisations are all the time learning something that is not stable, not even defined or understood ahead of time. In important transformations of our personal lives and organisational practices, we must learn new forms of activity which are not there yet” (Engeström, 2001a).

4.3 Summary of methods

“[I]n choosing a research strategy the scientist in large measure determines how the phenomenon being studied will be revealed, and indirectly the consequences of the knowledge thus generated” (Gödel, 1962). This section will practically outline the methods and design employed in using a DWR interventionist methodology in this research and it draws on previous empirical work in this area (Engeström, 2007a; Daniels, 2008:132; Edwards et al., 2009). DWR is therefore a useful way to address professional learning as it embraces and facilitates worker problem solving using tools such as the SCP which in turn can be modified during the process of expansive learning.

A DWR approach enables participants to address power, communication and division of labour issues (Daniels, 2009:113). It also facilitates dual stimulation and by so doing allows the researcher to understand what the workers are learning and what implications this may have for theoretical understanding as well as what forms of learning, organisational practice and dynamics are associated with said learning (RQs1&2). In order to achieve this the following methods were employed.

Design

The DWR methodology is appropriate to address the tensions between practitioners and the policies of the institutions that seek to influence their practice. This is particularly so in situations where there is little effective communication, or no overt recognition of difficulties, yet there is a need to productively change practice to meet policy demands and improved services for clients. DWR makes explicit what participants are learning and what changes they are making to their practice.

Structured interviews

Structured interviews were conducted with six members of the TLDTF partnership group, from various clinical and voluntary rehabilitation agencies, as a precursor to the main change laboratory sessions, in order to provide data to feed into the sessions. Guidance for the questions was taken from Kaptelinin et al, (1999) as set out in Appendix 4. The questions remained static although they were designed to elicit open-ended answers.

In this way data from the interviews could be used in the sessions rather than being generated by the researcher. The exercise also served to familiarise the researcher with the issues and dynamics of the network as well as identifying the tensions and contradictions which individual workers were experiencing.

A profile of the TLDTF area is in section 4.4. A further set of three interviews were conducted with three HSE senior managers as part of a pilot project to familiarise the author with conducting such sessions and to appreciate any degree of incongruence between the two groups. Sections 4.5 and 4.7 provide detailed explanations of the interview schedule and procedure, and the change laboratory process respectively. The interview schedule for the senior managers is not included. Modifications were

made to the original schedule in order to appreciate the role of the senior managers as policy makers and their position at the interface between other government departments. This change enabled the author to frame questions appropriate to their context rather than as practitioners.

Data collection

Interviews with TLDTP participants were audio-recorded, within a two week period in the office of a local agency, according to the schedule in Appendix 4. Each participant received and signed a copy of the information leaflet in Appendix 3.

Data analysis

Interview data was combed to identify data which depicted contradictions when compared to data from other participants or which, when compared with other external artefacts, raised contradictions in terms of policy and practice. This data could then be used as mirror data to generate discussion within the CL sessions and be augmented with CL session data as they progressed. This first form of data has been described as “ethnographic evidence” (Daniels, 2008:133) and is described further in section 4.5 in terms of the types of work data available. Essentially, the data collected represents examples which reflect current problems, which can be the basis for discussion, by examining the causes, difficulties and the experiences of those affected by these issues (Daniels, 2008:134). “In this way, critical incidents and examples from the ethnographic material are brought into Change Laboratory sessions to stimulate analysis and negotiation between the participants”.

Data analysis, post CL sessions, is described in Section 4.8 D-Analysis. It should be noted that in the LIW Project D-Analysis was undertaken between sessions (Edwards et al, 2009). Unlike this research project, the LIW fieldwork was undertaken over several sites with a much longer duration between CL sessions.

Pilot phase

The research plan was based on undertaking a trial run of the CL approach. The three HSE senior managers were used for this event after their structured interviews had been conducted and analysed. This enabled the author to familiarise and develop his role as a facilitator using a cam corder, projector, projector screen and three flip charts depicting the three dimensions illustrated in Figure 6, section 4.7 concerning the change laboratory.

Change Laboratory

The change laboratory sessions were conducted in three different but suitable group work rooms at three sites. The audio visual materials described in the pilot session were used. An audio recording was also undertaken as a backup in case any disaster occurred whilst the author was facilitating the whole complex process. The sessions were conducted with a gap of between ten to fourteen days between each session. This allowed the researcher, who also had a full time job, to analyse each session and prepare for the next session. The purpose of each workshop was to identify and promote change in the practice of participants by “. . . reconceptualising the ‘objects’ that professionals are working on, ‘the tools’ that professionals use in their multi-agency work and the ‘rules’ in which professional practice is embedded” (Daniels, 2008:134). The CL is described fully in section 4.7.

Accordingly, the planning of the first and subsequent CL sessions is important. A number of pre-prepared activity system triangles (Figure 2) was used to depict and remind participants of the process and provide examples of how they could be used to depict various situations. Guidance for such an approach is provided by the LIW Project (Edwards et al., 2009:179). However, in this research scenario no research team resource existed and all, between group, preparation and analysis rested with the sole researcher. The role of CL scribe (Figure 6) was not utilised as this would complicate the researcher role. This resulted in the researcher depending on the critical use of flip chart material and an ability to achieve a high level of coherence regarding the content of each session. In this way it is possible to structure data inputs, across past, present and future dimensions, as the sessions progress. The researcher anticipated that a significant amount of data would be produced and this will have to be considered in terms of its relevance generally and in relation to addressing the research questions. In view of the exploratory nature of this research the data must be identified even if it is not fully used. Therefore the data presented relates to the specific focus of the research questions whereas the rest of the data, whilst useful to understand the process of activity, was not relevant to the intention of the project

The researcher received assistance from an independent transcriber, who was subject to a HSE contract with confidentiality, efficiency and accuracy clauses. This enabled audio recordings to be transcribed quickly to allow swift data analysis. Parts of the cam corded sessions were used as mirror data in subsequent CL sessions and to assist the researcher in data analysis after completion of the fieldwork. There is always the possibility that permission for cam corded sessions will not be given or be rescinded.

4.4 Profile of the participants' geographical area

This section will describe the features of the Tallaght Local Drug Task Force and Dodder Partnership (TLDTFP) area and their natural efforts to employ a DWR approach. The generalised addiction client population in this area is similar to the national profile (Long, 2005; HRB, 2010) and is subject to what is a chronic relapsing condition across numerous care episodes which can include periods of hospitalisation and imprisonment. People with these problems experience a range of serious health, social and economic complications which impacts upon their lifestyles and life expectancy. Their behaviour, which often does not comply with ordinary patient expectations, often results in risks associated with relapse, recidivism, overdose and even death. The care and co-ordination of this group of clients presents significant problems in terms of continuity of service provision and interdisciplinary working. The shared care module provides the potential for an effective and faster method of communication between health workers (clinical and non-clinical) across all sectors. Overall clinical services (HSE methadone clinics and general practitioners) tend to adopt an insular discourse and have failed to embrace or effectively link with voluntary sector providers despite the channelling of addiction funding into the latter sector and the aforementioned policy imperatives.

The TLDTFP multi-agency and multidisciplinary workers have a history of innovative working in terms of local networking and the development of a “dual diagnosis” project directed at clients with drug misuse and psychiatric problems. Their previous efforts at networking provide a vivid example of collaborative working by engaging in activity which has addressed collective learning and the development of practice issues. This can be characterised in their development of knowledge from other workers in the form of distributed expertise (Engeström and Middleton, 1996:4), cognitive trails (Cussins, 1992) and learning in networks (Toiviainen, 2003). In this way this research project builds upon these naturally developing activities as a form of community development initiative and by so doing continues the process of area service development within a social inclusion and community development ambit.

This form of local network in the TLDTFP can be considered as a form of ‘collaborative intentionality capital’ (Edwards et al., 2009:32) and as an early unacknowledged attempt at co-configuration, a concept which has been touched upon earlier. Co-configuration is a working process of negotiation and adaptation in the effort to form a new product or end state. Co-configuration is a concept developed from Victor and Boynton (1998) which describes the type of work which is being crystallised in complex multi-professional environments. Warmington (2004:16) characterises this form of work in the LIW project as an analytical tool rather than as an actual description of reality of effective multi-agency collaboration. Current working within the TLDTFP suggests that their stage of development is progressing towards the realisation of this concept. Engeström et al. (1999; Engeström, 2008) takes the process one step further by identifying the practice of *negotiated knotworking* as “co-configuration does not capture the profound implications of what is called social production of peer production. Benkler (2006, p59) . . .” (Engeström, 2008:209). He explains that

“The notion of *knot* refers to rapidly pulsating, distributed and partially improvised orchestration of collaborative performance between otherwise loosely connected actors and activity systems. Knotworking is characterized by a movement of tying, untying, and retying together seemingly separate threads of activity. . . . The unstable knot itself needs to be made the focus of analysis” (Engeström, 2008:194).

The nature of drug addiction as a complex phenomenon with a relapsing nature can also be characterised as having a life of its own in terms of efforts to address the social problem. Engeström (2008:227) has described the concept of “runaway objects” which forms part of a framework for conceptualising distributed agency and social production. “Here again the *why* of action within an activity becomes a crucial aspect of dealing with unpredictability as the object of activity is followed and responses woven loosely together (Edwards et al., 2009:129).” “Runaway objects have the potential to escalate and expand . . . are poorly under anybody’s control and have far reaching, unexpected side effects. . .” (Engeström, 2008:227). Engeström seeks to develop his embryonic concepts further, and stretch the cognitive ability of his readers, via the use of agency metaphors such as “negotiated, communicative engagement with runaway objects in knots and mycorrhizae” (Engeström, 2008:231).

Back in the TLDTFP world there is potential for knotworking to address vertical and horizontal divisions set by organisational structures in which agencies, particularly the voluntary sector, are located. That is, whilst workers might have potential to co-operate at ground level the organisational structures within which they operate sustain their own identities, engage in turf warfare and are competitive with each other regarding government funding and allocation of referrals. This was seen to be the case in the LIW project:

“Relationships between horizontal and vertical learning are integral to the analyses of organisational learning currently being developed in activity theory. Engeström emphasises the importance of horizontal movement in expansive learning processes situated in organisational fields that are moving toward co-configuration work. These horizontal processes include ‘boundary crossing’ (Engeström, 1995), ‘multi-voiced dialogue’ (R. Engeström, 1995) and ‘negotiated knotworking’ (Engeström et al., 1999). The general working hypothesis of this study is that expansive learning of the kind required and generated by co-configuration is *horizontal* and *dialogical*. It creates knowledge and transforms activity by crossing boundaries and tying knots between activity systems operating in divided multi-organisational fields (cf. Engeström et al., 1999).” (Warmington et al., 2004:23).

The TLDTP, in common with other areas, is comprised of many different agencies and workers who are subject to competitive pressures (contradictions) in terms of differentiated worker roles, resources, client referrals and the pressure to sustain them in the face of general cost cutting measures and a depletion of resources. These points of contact are sometimes euphemistically referred to as ‘turf warfare’ and can produce tensions, contradictions and illustrated by concerns which focus on the interests of the agency rather than the client. These can also be interpreted in terms of Engeström’s (2001b) description of divided terrains (Cussins, 1992) of healthcare which reflect different levels of knowledge and skills based on a singular model of expertise associated with a particular field. However, there is also potential for positive communication, particularly between clinical and non-clinical workers, as there is potential for scientific concepts to grow downwards as everyday concepts grow upwards in order to creatively engage (Engeström, 2001a). This may well involve creating a new concept which arises from contested process within divided terrains which can be modelled by way of the expansive learning cycle. These cognitive trails can be conceived as traces of human activity, which develop via symbolic and social dimensions, by way of social practice over time. This process guides travellers (workers) across boundaries and obstacles. In so doing understanding can be dynamically and adaptively transformed in order to meet ongoing future challenges and tensions for workers and their practices.

“In such divided terrains, expansive learning needs to take shape as *renegotiation and reorganization of collaborative relations and practices between and within the activity systems involved*”. (Engeström, 2001b).

“Thus there is a need to focus on the ways in which professional knowledge, relationships and identities incorporate learning ‘who’, ‘how’, ‘what’, ‘why’ and ‘when’ in emergent multi-professional work. Moreover, it is important to explore the dynamic, relational ways in which professional learning and professional practice unfold. This means asking *with* whom practices are developed, where current practices lead *to*, where practices have emerged

from and around what activities and processes new practices emerge. These are concerns which recognise that professional learning in and for multi-agency working is embedded in fluid social and cultural contexts” (Daniels et al., 2007:535).

In conclusion, the TLDTFP participants represent a proactive group of individuals with great potential for DWR work. This is despite being disconnected from high level institutional structures and local clinical collaboration which isolates them from achieving their aims. Their efforts to date reflect natural attempts to collaborate, collectively, learn and to change practice to meet client and community development needs.

4.5 Fieldwork preparation tasks

Structured interviews were undertaken with clinical and non-clinical multidisciplinary workers from a range of voluntary and statutory drug treatment services using a prepared interview schedule in Appendix 4. The data were analysed to understand the individual functioning of each worker, the dynamics between workers and agencies in order to provide ‘mirror material’ for DWR sessions which reflected current and past practices as well as identifying associated contradictions and tensions. The material has the potential to be used as contributions to analyse issues and difficulties in worker practice and collaboration. These are regarded as ‘first stimulus’ artefacts to enable group members to reflect on work processes. As the DWR sessions progress other models, tools and artefacts are introduced to produce a ‘second stimulus’ in order to enrich and progress the historical and future development of solutions, practice and collaboration (Engeström, 2007a).

The structured interviews schedule was partly informed by the Kaptelinin et al. (1999) activity checklist preamble, based on the five principles of AT to assist in helping to identify important issues such as potential trouble spots. This included a focus on sections concerning: means and ends (hierarchical structure of activity), environment (object-orientatedness), learning/cognition/articulation (externalisation/internalisation) and development. These concerns permeated the main sections of the schedule which addressed questions concerning individual work (how this relates to other practitioners in terms of what people are doing, how and with whom they are doing it), membership of own agency (network and other fora), questions concerning community interagency relationships (learning, knowledge and information acquisition and boundary issues), examples of typical cases and worker visions of change to bring about ideal team/interagency working. These forms of data provided “ethnographic evidence” (Daniels, 2008:133) by questioning existing practice and analysing this to construct mirror data for the predetermined themes of the six change laboratory sessions. This could involve descriptions of problematic work situations, examples of tensions, narrative quotes concerning structural tensions relating to different worker practice, or relations between types of workers or agencies. Indeed, data could relate to future practice possibilities or received learning from similar change management projects.

Structured interviews, using a separate but similar schedule to Appendix 3, with HSE

senior managers was undertaken in order to elicit possibilities for their perspective to be included within the fieldwork. The use of senior managers does not appear to be a favoured activity in DWR research due to the limitations of bureaucratic perspectives concerning organisational change and the possibility that it is not directly connected to the iterative learning cycle (Warmington et al., 2004:37). It can be argued that senior managers are not relevant in that they are not directly involved in DWR processes and are not involved in tool creation or object-orientated analyses. Kerosuo et al. (2010:111) points out that managers are not in a position to meet the challenge of influencing and promoting organisational design (ibid Leonard, 1998) and that they are not in a position to link design with development, learning and practice (ibid Dunbar and Starbuck, 2006). However, given the importance of senior managers in developing HSE addiction policy, it was decided to interview them to discern whether they were a significant facilitating influence and whether they should be included in one of the CL sessions. This part of the research endeavour was an attempt to challenge existing DWR views in this area.

Proxy SCP Tool Construction

An effort was made to construct a proxy SCP module by using a SCP paper proforma (tool), as a proxy electronic health record, within Google Docs to progress workers' collaborative interaction using an imaginary client in real time. Workers would be encouraged to construct case examples in order to realise care trajectories and to construct, via learning, new practices which could emerge, via expansive learning, into a zone of proximal development.

Session outlines

These sessions focused on six pre-adopted themes to undertake DWR work with participants using a change laboratory approach and the shared care plan proforma as a tool.

Session themes:

- 1 Introduction to mini-lab (first CL session) to explain AT concepts, DWR methodology and gain permission to cam-cord sessions.
- 2 Use of mirror data, in relation to drug misuse, to explore official and unofficial perceptions (realities) of the geographical area and the statistical representations of the same. Introduction to Google Docs SCP exercise.
- 3 Examination of the client role, development of client care planning. Discussion of co-configuration, boundary issues and implications of policy and practice.
- 4 Session examining prison continuity of care.
- 5 Session examining alcohol and primary care team possibilities regarding policy and practice.
- 6 Closing session with review.

4.6 Ethical issues

Ethical approval for this research was granted by the Drug Treatment Centre Ethics Committee in Dublin and the School Research Ethics Approval Committee, University of Bath. Ethical issues were not problematic because real clients were not involved in this research. However, Bryman (2001) refers to Diever and Crandall

(1978) who highlight particular areas of ethical concern which might involve harm for participants, and these include issues concerning deception, breaching privacy and not obtaining informed consent. Within CHAT methodology emotional aspects of role strain or rule bending activity may well present an emotional challenge for workers and researchers within groups. In particular, new processes of horizontal learning and co-configuration could impact upon individual workers as they become less rigid and move to developing new forms of practice away from the comfort of their existing professional structures.

Postholm and Madsen (2006) consider ethical issues for researchers in positivist and constructionist domains and point out that special considerations should be adopted when utilising CHAT. They argue that the CHAT paradigm brings the researcher and participants closer together with inherent risks. The researcher has an active role to play and as such is subjective within the context of the DWR sessions to the extent that he “is co-responsible for changing processes throughout the research work *and* for creating a research text” (Postholm and Madsen, 2006).

The use of structured interview information should be congruent with ethical codes and must be collected without deceptive intent and with reference to worker privacy and confidentiality issues. The proforma concerning informed consent (Appendix 3) addresses these issues and includes the right to withdraw. “We would like to add that *honesty, sensitivity, mutuality, trust* and a *willingness to share competence* are ethical codes that can guide research in the CHAT paradigm. These codes also *challenge the researcher’s communicative, social and knowledge competence*” (Postholm and Madsen, 2006). It is contended that in this research the author has sufficiently addressed ethical issues concerned with the aims of the research.

4.7 Change laboratory

The change laboratory emanated from Engeström’s (1987) DWR approach. It provides an environment in which a group of participants can redesign their work and organisational activity by utilising and developing new models of practice, with the use of tools and practices, with the facilitation of a researcher. The change laboratory provides for a comparison between past, current and future practice. Accordingly, an appreciation of processes, motives, relationships and resistances, as well as periods of change or lack of movement can be comprehended (Engeström, 1999a).

“The laboratory sessions are designed to serve as microcosms where potentials of co-configuration and knotworking can be experienced and experimented with” (Daniels et al., 2007:530). The structure of change laboratory sessions are well described by both Engeström et al. (2007) and Daniels et al. (2007) and are depicted in Figure 6 which includes workers facing a 3X3 layout of surfaces for representing the work activity (Engeström, 2007b:10).

“The method used in the change laboratory is based on the notions of re-mediation and dual stimulation, derived from the cultural-historical theory of

activity (Vygotsky, 1978; Leont'ev, 1978; Engeström, 1987; Cole & Engeström, 1993)” (Engeström et al. 1996:4).

The mirror surface represents first stimulus which is often in the form of a challenging experience which in itself needs to be the subject of a reaction from the group members in which charged processes of denial or resistance may be expressed (Engeström, 2007a:11).

“In Vygotsky’s accounts, the ‘second stimulus’ is initially a neutral or ambiguous artefact which is filled with meaning and mediational potential by the acting subject. The notion of ‘neutral stimulus’ is, however, problematic. There are no neutral objects - every artefact has inherent affordances materially and historically inscribed in it . . . A closer look at Vygotsky’s work reveals that the notion of neutrality is actually not meant to be taken in any absolute sense. Vygotsky repeatedly used the example of experiments related to him by Kurt Lewin” (Engeström, 2007:11).

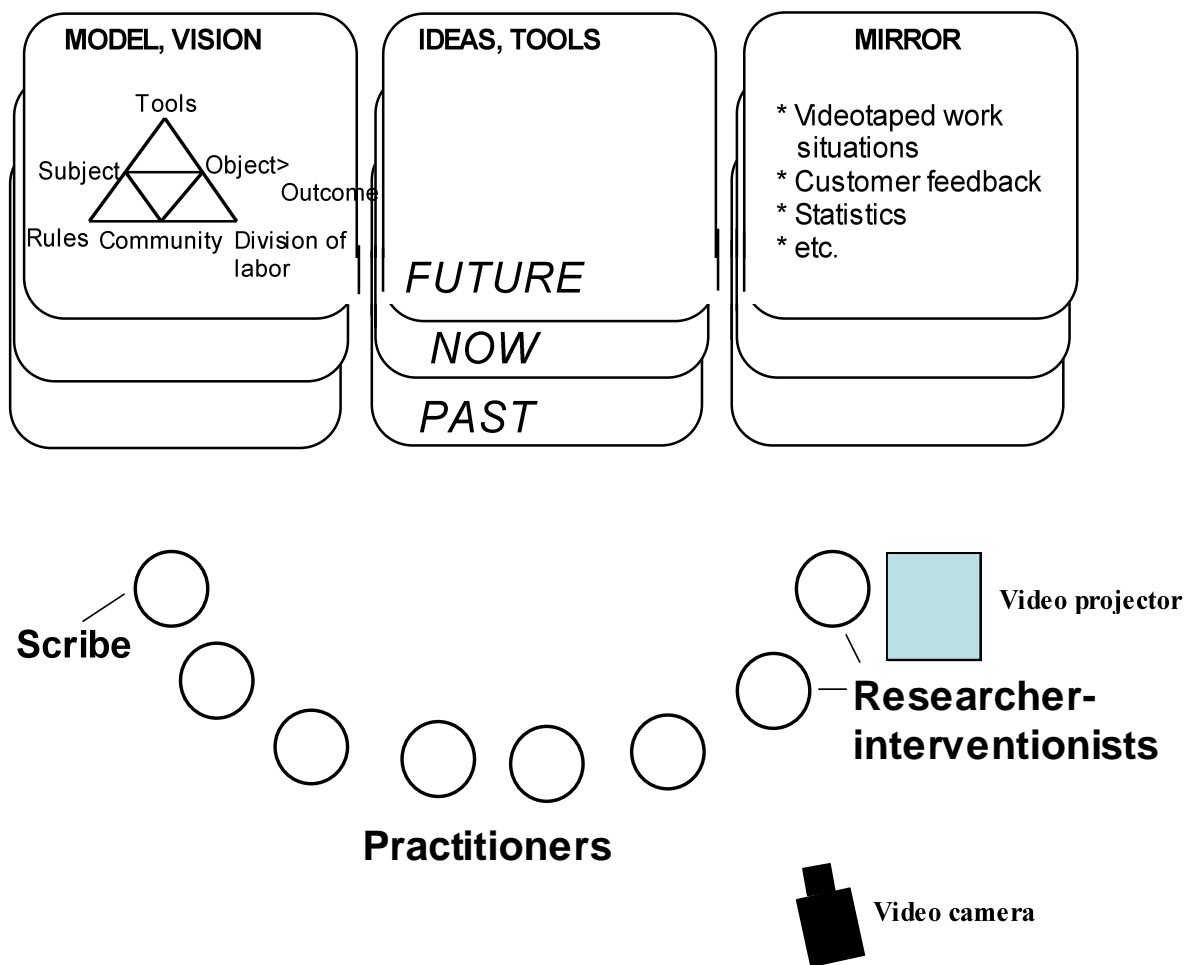


Figure 6: Change laboratory (Engeström, 2007a)

“In the Change Laboratory, movement happens in three dimensions. First, the gaze, the intellectual work and the practical representational work (writing, drawing, etc.) of the participants move horizontally *between the representational surfaces* of the mirror and the model, stopping occasionally in the middle to try and construct new solutions. Secondly, these processes move *between three layers of time*. And thirdly, the discourse moves *between the participants and their various voices and social languages*, including minimally a work team or unit plus one or more researchers/interventionists, optimally also representatives of management and clients” (Engeström, 2007a:13).

“The vertical dimension of the surfaces represents movement in time, between the past, the present, and the future. Work in the Change Laboratory typically starts with the mirror of present problems. It then moves to trace the roots of current trouble by mirroring experiences from the past and by modelling the past activity system. The work then proceeds to model the current activity and its inner contradictions, which enables the participants to focus their transformation efforts on essential sources of trouble. The next step is the envisioning of the future model of the activity, including its concretization by means of identifying 'next-step' partial solutions and tools. Subsequently, the stepwise implementation of the new vision is planned and monitored in the Change Laboratory. Such a cycle of expansive learning induced in the Change Laboratory typically takes three to six months. One cycle leads to the next one, and within the cycles there are smaller cycles of problem solving and learning (see Engeström, 1996; Kärkkäinen, 1996)” (Engeström, et al. 1996:4).

Each session agenda with supporting artefacts (Engeström et al., 2003) to address relevant issues in relation to the division of labour (in terms of past, present and future practice) determined by collaboration between the researcher and a core group of professionals who will be in each session. In this way the aim of the workshops is to recognise the areas that require change in working practice and crystallise possible change by re-conceptualising the objects that the members are working on and the rules that impact upon them. “In a professional context where so much emphasis is placed on skills and knowledge this form of work is important because it tacitly recognises that desired forms of practice require professional ways of being, as well as skills and knowledge” (Daniels et al., 2007:531).

Daniels (2007:535) refers to accessing distributed expertise, both formally and informally as being a key issue (via what, how, why and where to questions) in understanding the knowledge and modus operandi of other workers. This is a fruitful area for surfacing contradictions in interprofessional working. The inclusion of the SCP tool acts as leverage for workers to develop the practice that is required for its use. Whereas, in the LIW context, DWR could be subject to negotiation which may or may not lead to the development of new tools or practice or indeed the “new professional identities” which may pertain (Engeström, 2007a; Daniels, 2007:533).

The use of the expansive learning cycle within the change laboratory interventions only provides a partial explanation of movement through each stage of the expansive

learning cycle and leaves a lot of interpretation regarding the empirical translation of his model (Engeström, 1999a). However, these understandings can be surfaced as tensions and internal contradictions which can be worked upon in movement towards new forms of practice within the zone of proximal development. These contradictions are necessary to drive the transformation process to change and evolve.

Contradictions within an activity system

Contradiction is absolutely central to the dialectical developmental change that AT proffers. 'Contradictions are historically accumulated structural tensions within or between activity systems' (Engeström, 2001a:137). Such tensions, Engeström (1987) argues, takes four forms:

Primary contradictions evolve within an activity system when part of that system contradicts itself. [Monitoring and evaluation reveal funding objectives are not being fulfilled as other objectives are being pursued]

Secondary contradictions occur when an element is introduced into an activity system and that element contradicts a part that pre-dates its entry. [Use of SCP proforma]

Tertiary contradictions occur when a new object of activity is introduced and that causes a challenge to the existing system because that new object (practice, policy or technological) has been created elsewhere. This new object may be culturally different or may invoke anxiety, confusion, resistance, and tension. [HSE integration policy, NDRIC framework, use of EHR]

Quaternary contradictions occur between systems and they can affect internal processes within systems as well as interactions between networks of activity systems. [Different agencies focusing on client centred need resolution whilst having conflicting goals and interests].

Contradictions within and between activity systems are the drivers of change and motivation and can result in major transformation and change via frequentative cycles.

"Each transformation is both social and material; it is durable and irreversible. Objects, actors, and activities persist over time; they have trajectories. AT provides a strong historical account of how activities weave and develop and how they splice with other developing activities that share the same object, forming activity networks. It provides a woven understanding of activities, which become more complex and can eventually split into a network of related activity systems. But it also provides a spliced understanding of how these might link with other activities. We get to see how these spliced activities transform the object – and each other – dialectically, through contradictions that are periodically addressed with systemic changes" (Spinuzzi, 2008:122)

4.8 D-Analysis

Collaboration between activity systems is essentially a learning activity directed at appreciating the socio-cultural and historical aspects of previous and current practice with a view to forming distal new practice to meet policy requirements, effective collaborative working and to contribute to the successful roll-out of these SCP concepts within the SCP module in EPS. The fieldwork will be subject to D-Analysis (Middleton, 2010:96) which will elucidate the described process.

D-analysis is based upon the identification and analysis of sequences of defined stages of communicative action (Middleton (2010:96) which may pass through some or all stages of those stages. It examines "what-it- is- to- learn" (Edwards et al., 2009:150). This CHAT-based analysis, used in the LIW research, can be expanded to assist a CR and a Bernsteinian analysis. These strands may also have significance to other concepts and strands identified in the literature review.

Middleton proposes that D-analysis be used following completion of all DWR sessions.

"One of the main analytical challenges of the study was to move from the use of predefined CHAT-based concepts used in the intervention phase of the project, to a comprehensive analysis of the communicative action across the total data corpus recorded in the DWR intervention sessions " (Middleton, 2010:91).

The D-analysis protocol is based on an analysis of movement of discourse analysis from what has been established to that which has yet to be established and how it is to be achieved. In this way work and new practice can be envisioned and reconfigured in practice. This will require analysing participants' movement in terms of boundaries and division of labour with other workers and agencies. This includes analysing the boundaries between them as well as the demands of working using the SCP tool as a vehicle for crystallising that new practice within its conceptual structure. This makes visible what the issues are and how this is observed as a developing learning process. This is not a once off process as it involves a group of workers assisting in an activity. It is therefore important to understand that process and make it visible. This is what concerned Middleton (2010:94) who identified distinctions of practice so as to ". . . make the difference (cf. Bateson, 1972/2000)". This was developed by utilising the following 'D-Analysis' protocol: Middleton (2010:96).

"Deixis: identify when there is some nomination or 'pointing' to a particular issue in terms of drawing attention to a distinction that is then worked up to make a difference in subsequent turns.

Definition and delineation: look for how that issue is elaborated in the uptake of others in terms of how the following are warranted and made relevant through: (i) qualifications identifying further distinctions; (ii) orderabilities in the organisation and delivery of past, present and future practice; (iii) expansive elaborations of the problems of practice.

Deliberation: identify how some working consensus on what is the case emerges in terms of evoking particularities and generalities of marking distinctive features of the past, present or future practice".

By identifying strands (of deixis, definition/delineation and deliberation) significant sequences are crystallised and made visible in terms of new multidisciplinary working as they lead to the departure from current practice and the possible development of new practice. In this way:

"Departure: identifies shifts towards quantitatively different positions in practices in terms of the formulation of emergent distinctions.

Development: identify when participants specify new ways of working that provide the basis for becoming part of, or have become part of, what they take to be and warrant as a significant reformulation of their practices".

"Its cyclical use application enabled: reading, reviewing, interrogating, collating and comparing all the audio-visual evidence from the intervention sessions in order to identify the emergent strands of learning".

Middleton (2010:102) believes that this process also enables linkages to an institutional dimension involving social context and the identification of social dilemmas and the possibilities for the reformulation of practice, strategy as outlined by Daniels (2005; 2006) and others.

Chapter 5 Data Analysis

5.1 Introduction

The CL sessions produced a wealth of important data, which can be found in Appendix 2, for use within and outside this study. The most pertinent data have been selected for analysis in this chapter to focus on the research questions and the development of the SCP tool, and to study the object-orientated process which created a new form of working with GPs. The data presented in Appendix 2 illustrate all the D-analysis themes in the DWR process. Many of these themes relate to governance matters which, whilst relevant, do not fall within the remit of the SCP tool as they are determined and audited by local governance structures. This distribution of power and responsibility may well be centralised in the future. In addition, this chapter will demonstrate the process of how the data were managed, including the development of new analytical proforma as an example of applied research that can be emulated by others. The transparency of this approach is unusual, in this type of research, which tends to provide limited examples of text to demonstrate the form of analysis.

This chapter will present the findings in relation to the six CL sessions described in the last chapter. This will be done to reflect the process adopted within the sessions and as an example of applied research which can be emulated by others. The transparency of this approach is unusual, in this type of research, which tends to provide limited examples of text to demonstrate the form of analysis. This chapter will provide a greater illumination of the process adopted in the study, including the development of analytical proforma to assist others with similar complex interventions which require the cognitive organisational skills of a circus ringmaster.

5.2 Structured interviews

Interviews were conducted with the participants using the detailed schedule in Appendix 4. The interview data were analysed and used as mirror data. Interviews were also conducted with senior managers to ascertain the congruency of their approach with participants and to get a sense of official discourse in relation to policy and practice issues. As mentioned previously, the involvement of senior management, other than in relation to gatekeeper roles, might reveal important understandings and was also a reflective device for the author as he fitted into the same category.

Analysis of the latter data was not as illuminating as hoped, although it did give a good understanding of their commitment to policy and associated practice aims. Surprisingly the managers' commitment to develop the rehabilitation pillar as a form of social movement was quite striking. In terms of official discourse the motivation or strategies of the senior management group did not reveal anything other than positive views in terms of practitioners forwarding the national drug policy agenda. No mirror data were used from these meetings and it was decided not to involve the managers in any of the DWR sessions.

5.3 DWR sessions

DWR sessions were conducted according to plan and session one took the form of a mini-lab as described by Edwards et al. (2009: 176) as participants received instruction on DWR and essential principles of expansive learning and co-configuration. The researcher was able to utilise the group's experience of developing their dual agenda project to describe features such as distributed working and knowledge trails. Session 2 also involved a certain amount of education as new participants turned up. Despite the necessity of educating participants about DWR it became obvious to the researcher in session 1 that swift ordering and analysis of gleaned information would be important in maximising gain for the session and in terms of feeding into developments across all sessions. To this end the Practice and Organisational Development (POD) form was developed and this was a permanent feature of mirror data presented within sessions. This approach connected the development of data across all sessions. It was also useful in keeping group order to discourage any participant straying into areas of unconnected discourse. Consequently, the completion of the POD form developed over time and resulted in the exposition of full and partial threads of idea development and object-orientated activity. Table 7 is an example of this form. The numbering in the text refers to the CL session number and the page number.

The POD form was developed so that the researcher could manage data and idea development on an ongoing basis and to ensure that data fed into each subsequent DWR session. The POD form structure, which was divided into issues, tensions and contradictions, past practice, current practice and future practice; allows for a structured and clear understanding of DWR progress over time. The POD form was completed over time, subject to changes, and based on the work conducted within the CL sessions. It did not include researcher preconceived items as depicted by Table 4 in Chapter 2. The POD form was used as mirror data to stimulate discussion and refer to process and progress in terms of the development of new practice. It also laid the basis for the use of D-Analysis (D Analysis Form) in terms of issues thread development. For example, the thread in Appendix 2, Table 11, checking reality – official statistics give one perspective, worker comments suggests another. Not all threads were fully developed and some were subsumed into other more developed threads.

The researcher discovered, after the fieldwork sessions, that Pirkkalinen and Kaatrakoski (2009) developed a hybrid laboratory (HL) method in order to address multi-voiced, multi-level and cross sectoral aspects of organisations. This model depicted by Figure 7 displays the process of data development across sessions, which in the HL sessions includes the involvement of other organisations. "However, it is important to bear in mind that in some respects, HL differs quite a lot from the original CL method. This is partly because one of the aims of the project was to develop and to pilot a new kind of intervention method. One central difference is that traditional CL tools are not necessarily used in the analysis. Further, in the pilots, the analysis did not focus on the object of the activity, the historical analysis was not

made in a careful manner and the intervention did not proceed in three steps: analysis, design and evaluation” (Kaatrakoski, 2009).

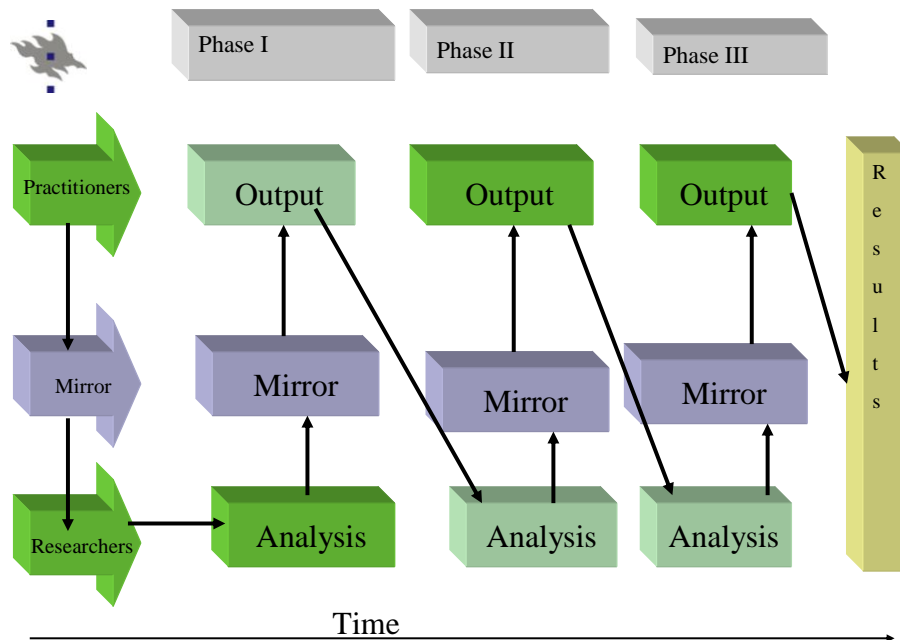


Figure 7: The structure of the Hybrid Laboratory Process (Pirkkalinen and Kaatrakoski, 2007)

Although this researcher was not aware of this hybrid model at the time there are some similarities with the development of the CL process adopted in this study. The development of the POD form, and its ongoing use in progressing CL sessions, as well as facilitating the introduction of new members in later CL sessions on the prison activity system and the PCT activity system, resembled the process illustrated in Figure 7. In this study phase boxes would be replaced by CL session numbers from one to six. In this way one can order developing data and feed this coherently into subsequent CL sessions as mirror data. This was possible by the researcher not being too directive and observing the outline development of naturally and progressively occurring sequences. Not all data developed into partial or fulsome sequences but it remained as isolated but relevant data in the POD form. The D-analysis provided the critical analysis required to identify and progress critical operational possibilities for practice change.

The use of the hybrid model in the Tampere example included organisational structures outside the worker structure. Efforts to include senior HSE official in the ethnographic structured interview stage was insightful but not that productive within the CL process. This might confirm Warmington et al. (2004) observation concerning the limited usefulness of bureaucratic involvement in the practice change management process. On the other hand the role of senior HSE management and

other relevant managers from partnership organisations could be useful to facilitate the EPS deployment planning process.

5.4 Google docs experiment

Efforts were made to introduce between session homework activity in terms of the construction and dynamic use of a shared care plan using the SCP proforma on an Excel spreadsheet in Google docs. This facility allows real time shared working in a collaborative context and has the advantage of simulating the shared care plan in an electronic format. One of the participants was encouraged to put up an example on Google Docs and the others were regularly invited and prodded to participate over time. They failed to participate. Later another participant compiled another case example using a SCP paper proforma to reflect a prisoner throughcare case for a CL session.

Prior to CL session 6 the researcher compiled another paper SCP proforma using elements of the two mentioned example proforma and observations from previous CL components to outline a SCP wrap-around care package for GPs. This document (see Appendix 1) proved to be a high level schema which contained all the design concepts of the proforma and a very practical example of multidisciplinary working and care co-ordination and co-configuration regarding the formation of a care trajectory. In session 6 this document promoted an attack (resistance in DWR terminology) on the use of the SCP from an organisational perspective and may have reflected anxieties associated with the potential realisation of the forthcoming change process with the introduction of the EHR system. This can be seen in Appendix 2, Table13.

The failure of this exercise was very disappointing for the researcher but can be possibly explained by the fact that real client situations were not used. Similar role-based exercises have also failed to produce the desired change impetus in other areas (Colm Keating, personal communication, May, 2011). The upshot was that the SCP GP wrap-around example has been used extensively to illustrate the benefits and process of SCP and ICP activity in the national deployment of EPS.

5.5 Analysis of tables

This section will undertake an analysis of the data collection process and production of the tables 7-9 in this section. In this way the DWR process will be illustrated and examined in order that the reader can understand and interpret these occurrences. It is also important that this process be replicated for the proposed national roll-out of EPS and for others to duplicate. In this way ideas, germ cells and generative mechanisms can be transformed into possible new practice and theoretical understanding. As mentioned in the CR section the generative mechanisms developed and recorded in the CL sessions can be seen in CR terms as “tendencies” which allow for abstraction, abduction and retroduction” (Lawson, 2006:262).

These aims are congruent with the comments previously related to Engeström (1999b) concerning the importance of the researcher carefully and systematically documenting ethnographic material and learning to ground theoretical ideas. This is a form of instrumentality which implies “. . . that the instruments form a system that includes multiple cognitive artefacts and semiotic means used for analysis and design, but also straightforward primary tools used in the daily practice and made visible for examination, reshaping and experimentation. In such a dense mediational setting, a set of interconnected new socio-cognitive processes are called for - literally, a new mentality is to be generated. The very complexity of the setup means that the instrumentality is constantly evolving; old tools are modified and new tools are created” (Engeström, 1999b).

“The developmental interventionist needs to record, analyze and support these processes. The researcher needs to record and analyze also his or her own actions and interactions. Interventions themselves must become an object of rigorous study” (Engeström, 1999b).

The following tables in this chapter allows for such an exercise to be conducted concerning the development of the SCP GP care package. Appendix 2 provides two other illustrations concerning the “Development of a Tallaght model” Table 12 and Table 11 “Area profile D-analysis Form” strands. Table 14 provides an overall view of all strands in relation to the research questions.

In this section an analysis will be undertaken of the development of the Shared Care Plan GP package (SCPGP) as portrayed in Appendix 1 and developed via tables 7 and 8. This is a distinct new idea which via DWR was crystallised into a potential new way of working between voluntary sector workers, GPs and the PCT. This can be seen as the emergence of a new form of consciousness in that it addresses defined problems in a collaborative way and by so doing develops a new form of conceptual structure and practice. It embraces a new form of working with the recently developed HSE primary care strategy which aims to move from an old style of working to one which adopts a multidisciplinary primary care team structure for health and social services within local geographical areas.

‘Table 7 GPs, PCT, wrap-around care packages care trajectory and alcohol service POD form’ was partially completed prior to its use as mirror data for CL6. This form identified problem issues from previous sessions which were beyond the scope of the participants to address. The HSE Alcohol adviser and the local HSE PCT co-ordinator attended CL6 to assist in problem resolution as many issues had been raised and no conclusions had been reached how to translate the identified problems into new practice.

Table 7 reflects a concern with alcohol and PCT issues. Alcohol issues were identified in previous sessions as indicated in Appendix 2, Table 14, item 4 and Table 10 POD form. Alcohol issues were not being properly recognised in official statistics yet participants knew this was an issue on the ground. Therefore, drug users were developing a cross addiction to alcohol and were not being provided with appropriate treatment interventions. In Table 7 the local alcohol service is recognised as an insular service provider and a threat to SCP development as it insists on clients being referred for standalone treatment without multidisciplinary engagement.

Whilst this is so the alcohol service provider is willing to engage with local voluntary agencies to train them to provide alcohol awareness courses and a practice intervention toolkit.

Table 7, column 2 depicts a concern about methadone substitution being never ending “and does not address the way out.” Such a concern is also recognised in columns 3 and 4 relating to past and current practice respectively which point to limited communication between GPs and other workers.

A depiction of current efforts to roll out HSE PCT policy, by developing local PCTs is commented upon in column 4. Problem issues are identified and associated with the early stage of the programme from moving from an old model of practice to a new primary care team structure centred on local GPs and their attachment to a multidisciplinary team of health workers. These PCTs do not have a relationship with the voluntary agencies some of whom are participants in the CL sessions.

Table 7 column 5 projects future possibilities in terms of rehabilitation as a social movement. It also indicates a possibility of providing a SCPGP package as “a new offer” to the PCTs. The references to other workers in the PCT in column 5 refer to the possible need for liaison with a public health nurse. Table 7 concludes with the decision to setup a SCGP pilot project to engage in collaborative working with a local PCT.

In Table 8 (‘Potential for use of SCP as a wrap-around care package for GPs and PCTs as part of EPS D-analysis form’) alcohol issues, via D-analysis’, are translated into a potential model of service provision in the proposed SCPGP package.

The main thread relates to the process by which participants developed the SCPGP package. The components of this form reflect tensions depicted by GP behaviour some of which was contested by the GP participant in the CL. Issues centred on the portrayal of GPs as sole traders with limited time and a concern for pecuniary matters. Such concerns focused on the high time demands associated with drug misuse cases and the attendance of meetings for which GPs are not paid. Risks of working with drug users were identified and these related to the lack of support that GPs could avail of given the risk behaviour that some users displayed. Hence, the development of the idea that a SCPGP support package could be mutually beneficial for all parties.

Section 4.9 describes the D-analysis process and Table 8 provides the data used to draw out the strand from the data. Table 8 is based on the D-analysis derived from all the transcripts and POD data. It is useful to interpret this table as sheet 1 and sheet 2 and to be aware that both alcohol service and PCT services are addressed in the one session. The two are really separate features and it may be confusing for the reader. The reality is that alcohol issues are important and they are intertwined with drug treatment issues. Alcohol abuse is also an important issue in primary care. The next national addictions policy plan will include alcohol and drugs issues in a combined addiction strategy.

Table 8, Column 1, the deixis, nominating an issue stage emanated in CL5 and is titled 'Potential for use of SCP as a wrap-around care package for GPs and PCTs as part of EPS roll-out'.

Column 2, sheet 1, identifies or points to the issues to be worked on and refers to the identified need for SCP and the real time advantage that an EHR can provide including addressing current risk issues. Efforts to work out a care trajectory are explored, although attempts to consider mental health and child care existing networks in the face of resource and organisational constraints, could be seen as over-ambitious at this stage. The essence of working with GPs was pithily described as "How to engage GPs as they are sole traders who want things to be practical and immediate". Issues to be worked on were identified in terms of protocols, guidelines and the re-configuration of existing networks within current resource and organisational constraints.

Column 2, sheet 2 identifies essential points of difficulty and tension which need to be worked on, elaborated and addressed in terms of practice development.

Column 3, sheet 1, deliberation stage, refers to working towards developing a consensus based on perceptions of past, current and future practice. The PCT co-ordinator is perceived as having some difficulty in appreciating what was on offer in terms of the SCPGP wrap-around care package. The elements of this package had been developed in previous CL sessions to which she was not privy. Therefore, the PCT co-ordinator may have had a difficulty in understanding the concept and its implication for the PCT organisational structure which she was attempting to develop.

Column 3, sheet 2, identifies and agrees on particular topics to be worked on such as education of other workers, developing an agreed conceptualisation of case management and an appreciation of client role strain if each agency makes different demands on the client.

Column 4, sheet 1, departure stage, works on the emerging consensus about developing the possibilities of a new form of practice. "Is it a possible reality that we could develop this into something"? This suggests that movement made towards use of the SCP, and in particular the generation of the new SCPGP wrap-around care package, as a conceptual structure is a shift towards a radically different form of practice based on emergent distinctions. The potential of this as a new form of practice could have major benefits if it proved doable.

Column 4, sheet 2, expands the area of work to be addressed with new PCT participants in terms of potential network changes as opposed to just referring a client onto another stage of the care trajectory without relevant continuing worker involvement. System threats were identified in terms of ever increasing client numbers and problems relating to the management of confidentiality issues between clinical and non-clinical workers. Reference made to national policy aims as a source of direction and support for the initiative.

Two references made to alcohol issues raised earlier about whether there is a need for a separate alcohol model to that for drug misuse and whether alcohol issues can be included given the propensity of the local alcohol service provider to prefer a standalone service model. Possibilities for copying required interagency protocols from childcare were considered.

Column 5, sheet 1, development stage, is where participants specify how that new practice is to be progressed by identifying new ways of working. These are specifically listed in column 5 and focused on the agreement to initiate a pilot project. The last two points in column 5 temper enthusiasm by recognising difficulties which may impinge on the process. Column 5, sheet 2, suggests that reconnaissance should be undertaken of local care teams to elicit features which could be embraced for the proposed work with local GPs and PCTs. This included alcohol service development. In conclusion, whilst the potential of the SCPGP package was clearly identified the PCT co-ordinator could not fully envisage the process or what the CL participants' expectations were. This suggests a leap of faith is necessary, in this phase, to move the process forward.

Table 9, item 11 was developed in order to relate the research study to the research questions. It highlights the features of the two previous tables and pithily describes the issues involved. Whilst this table format was only devised during the data analysis process it has potential along with table 8 format to further the learning process with participants undertaking lengthier DWR projects. The alcohol component in the previous tables have not been include in this item but can be seen in Appendix 2, Table 14, item 4. Whilst there is potential for this table to connect to practice and theory issues in a more obvious way, as seen with other items in Table 14, this is not always the case. However, Table 9 does not provide the best example of this. Column 2 does identify the creation of the SCPGP care package as a significant development which has potential to address existing communication problems between participants and GPs. It acknowledges that the development of the local PCT model is having some difficulty in establishing itself and suggests a possibility that the SCPGP initiative could add a mutually beneficial component for both PCT development and addressing the needs and risks of clients who progress to GP care.

Column 3 recognises differences between ordinary workers and those workers with clinical positivist skills and knowledge bases and the efforts being made "to traverse major multidisciplinary lacuna" with new supporting network structures. Column 4 notes the pressurised environment of PCT workers struggling with the development of a new PCT model whilst at the same time being asked to consider the SCPGP package the benefits of which are not fully understood.

Column 5 relates to researcher comments, outstanding issues and contradictions for potential further development. The case example in Appendix 1 was recognised as having enormous potential as a high level schematic device which explains the overall concepts at a glance. This example was used immediately by the researcher for persuading others, outside the environs of this research study, to extol the potential benefits of the EPS EHR.

In concluding this analysis it is important to state the importance of the D analysis in illustrating how it facilitates the emergence of a new form of consciousness. For example, when appreciating the significance of Table 8, as a headline example of a thread from the POD form (Table 7), as depicting the emergence of a new form of consciousness. In this case it can be seen that the D analysis illustrates the process as it effectively identifies and analyses the sequences of communicative action. In essence two groups of fragmented service providers (PCT and voluntary sector agencies) see the opportunity for collaboration to form new practice based on identified client need and the mutual use of the SCP tool. This is based on the requirement to negotiate a new referral pathway between them and negotiating shared care planning, boundary crossing and new division of labour between workers. The deliberation phase recognised differences in knowledge and skills between workers and an effort to address these with the aim of devising new mutual combined practice. Indeed practical tasks are considered in the development section of Table 8 to achieve these aims despite current work pressures and the activity being a step into the unknown.

Similarly an example of developing new consciousness can be found in Table 12 in Appendix 2 which considers the potential development of the Tallaght model of practice by using the D analysis format. The idea of a Tallaght model of practice was raised several times during the fieldwork process and related to the proactive work of the participants which was described in section 4.4. This idea was also verbalised, by the researcher, much to the embarrassment of the participants, and can be found as a component of threads in other tables. Table 12 uses D analysis to consider the possibility of developing such a Tallaght model. The deixis stage identifies the crux of the matter in terms of the mandate for developing such a model and the implicit power considerations. Column 2, definition and delineation, identifies the problems with current practice and defines how the issue is to be elaborated in terms of practice. The deliberation column pulls together a consensus regarding workers' past, present and future practice as well as identifying official influences upon that practice. This enables the crystallisation and identification of possibilities. This could be progressed by translating official policy into practice, devised by the CL participants, or by not allowing individuals to base practice on their own individual belief systems but on an agreed collective forms of practice. The departure column identifies shifts to new forms of practice via the potential use of monitoring, education, guidelines and new divisions of labour. The development column identifies new ways of working in order to realise the objective by using 'evangelist' type workers, new protocols, new networks and the use of the SCP tool. The participants felt that the proposed alcohol treatment project would be the way to realise their aims and that other agencies would follow.

Table 7: GPs, PCT, wrap-around care packages care trajectory and alcohol service POD form

POD FORM				
Issues	Tensions & Contradictions	Past	Current	Future
<p>GPs, PCT, wrap-around care packages and care trajectory. Alcohol service Nature of current service (as above). Existing PCT development? Role of key workers. Retreat into professional bunkers. Influence of NDRIC doc.</p> <p>“The base is being eroded but new service and practice is required in a way that evolves to meet constant changes”.</p> <p>“Fear of ownership and reporting frightens people”.</p> <p>Alcohol perspective not included. GPs isolated sole traders with no engagement with SCP&ICP unless money in it. (CL1/446,CL1/525) & provide only scripting MMT so lack of support to clients despite progress to that point. Half of CTL with GPs, 1/3 with vol sector yet both not properly utilised.</p>	<p>Risks for GPs. Nature of GPs as self employed practitioners (non-engagement). “How do we document interaction and safeguard practitioners?” (2CL808).</p> <p>“In my clinical judgement it is [treatment and system interpretation] whatever I want it to be”.</p> <p>No current effective communication with GPS and when there is depends on their mood. GPs not making money on GPS patients. List negative traits of GPs with drug misusers (754-767).</p> <p>Maintenance of existing central treatment model suits psychiatrists (801).</p> <p>Accumulative aspects of MMT as it just adds patients to the list and does not address the way out (846). Wheel of change, decision and action (831).</p>	<p>“I have tried to talk to GPs for 10 years” [about multidisciplinary working to little avail]. Very limited contacts with GPs.</p> <p>GPs are sole traders with an eye on the money.</p> <p>“Addiction is not an interest or a professional competence of GPs”.</p> <p>Alcohol an insular service due to policy history of being left alone. Their views [on continued insular practice] poses a threat to SCP module.</p> <p>Alcohol service positives include their potential for training other workers, provision of tool kits and development of community awareness for voluntary service providers.</p>	<p><u>Primary Care Strategy roll-out</u> Reconfiguring services into core teams is problematic and link to networked services CL5/519 Addiction resources not networked service to PCT like mental health?</p> <p>Low level of multi-d working. <u>PCT situation:</u> Don't have single point of referral, no admin support, meetings take too much time. They have individual & not multi-d waiting lists & individual worker care plans. Therefore multi-d working & work pressures with complex cases difficult. Too many protocols and guidelines. Effort to effect change is enormous. Care pathways and trajectories not crystallised (568). No physical co-location. Work pressure prevents staff doing a 'mental space'shift' 593</p> <p>PCT not appreciating offer of addiction support package (CL5/618,500, 699).</p>	<p>“Rehabilitation as a social movement” [possibility]. “So, if we have a new offer, a new structure and a new package and we are saying we can take a lot of responsibility off the GP and give it to Worker 1 and let him boss or manage the system and they have a significant but only a part to play” (CL1/502). Key working GP care packages (630). “GPs like to see things practically and of immediate benefit” (CL5/550).</p> <p>Possible effective use of practice or public health nurses (568). “PCT nurses won't take on addiction per se but they might consider the context though” (630). PCT refer to HSE MMT clinic rather than dealing with things locally (665, 690). PCT leader up for pilot (881-893) project offer from vol sector 680,717,768, 862).</p>

Table 8: Potential for use of SCP as a wrap-around care package for GPs and PCTs as part of EPS D-analysis form

D-Analysis Form				
Deixis	Definition & Delineation	Deliberation	Departure	Development
<p>Potential for use of SCP as a wrap-around care package for GPs and PCTs as part of EPS roll-out (CL5).</p>	<p>Real time sharing of info has major impact on potential practice changes (507): Lowers risk for GP. More than just scripting.</p> <p>Identified contribution to reconfiguration of PCT staff occurring (519) into core teams in a network.</p> <p>Work out referral path to networked services for mental health and child care early intervention teams. Developing multi-d teams an objective (550). How to engage GPs as they are sole traders who want things to be practical and immediate (557).</p> <p>Lots of guidelines and protocols but working out how to get teams to gel is the issue (560). No admin support services which are stretched. Problem filling posts impacts on organisation and multi-d. practice.</p> <p>Attending clinical meetings</p>	<p>Need a solution/system to address column 2 issues</p> <p>Big cultural shift to new working practice required (581).</p> <p>Teams are not co-located but need to be (584).</p> <p>Clinicians don't know about potential rehabilitation contribution.</p> <p>"Workers don't have the mental space to start thinking [about new practice] (592).</p> <p>[Difficulty in getting over what is on offer to PCT. This resulted in developing a special SCP example for this potential service/new practice. [See Appendix *]</p> <p>"I am struggling to understand what you could be asking of primary care" (Worker 4, 666). Cult of individual worker</p>	<p>"Is it a possible reality that we could develop this into something" (615).</p> <p>"We could look at possible links between Agency 5 and GPs"</p> <p>"Get PCT teams to understand the network and pathways through services" (666). Education for teams on how</p>	<p>Develop pilot project with 12 patients and GP (882; 761-896).</p> <p>PCT to invite CARP person into multi-d team if client is OK with it (702). Training required for this pilot team (addiction education, wheel of change and motivational interviewing) (709).</p> <p>"Maybe if you picked a PCT working like this already?" (763).</p> <p>Current PCT reality needs to address:- "Full GP waiting room-they don't have time to engage with addiction clients" (761).</p> <p>"They don't have time to discuss patients with complex needs and attend multi-d meetings 761</p>

	<p>uses up valuable [unpaid] time for GPs (566). No single point of referral to PCT so multiple waiting lists (542-571). Problem in bringing forward complex cases for multi-d working (568).</p> <p>PCT workers get rid of clients with addiction issues by referring them on (638-656).</p> <p>At the moment most clients with GPs only get scripting service and not the supports they need (734).</p> <p>"GPs not making money on GPS patients".</p> <p>"Better GPs do nothing rather than be negative" (741).</p> <p>"Many GPs not skilled in addiction area but clients are" (777).</p> <p>Accumulative aspects of MMT. "We take them on and don't get rid of them" (849).</p> <p>Problems raised in relation to case management in child care sphere (944) and the ones contained within NDRIC framework doc. Agencies have differing agendas (998).</p>	<p>(978) [e.g. counsellors, other persons philosophies (971).] Need to be client centred in approach (981).</p> <p>How to manage deviant aspects of clients?</p> <p>"Case management is a common working practice amongst agencies" (1018). How to manage this in a multidisciplinary context?</p> <p>SCP has some of the answers to these identified issues.</p> <p>"Danger of clients doing different dances for different agencies".</p>	<p>it could work. Rather than just refer on and forget about it. - "Big piece of work" (671). Lots of contributions from other agencies to package – "you don't need to be professionally qualified" (685).</p> <p>"It is also on a need to know basis –they don't need to know everything" [confidentiality issues].</p> <p>Note accumulative MMT client numbers whilst alcohol clients go in and out [cases opened and closed after treatment] (849). [Do alcohol services have a potential model?] "How do we achieve integrated services?" (864). "Get the right people to drive the initiative – like the evangelist services do] (104).</p> <p>Possible modification of local childcare information sharing protocols.</p> <p>HSE policy and reports backing and heading drive for change [If only they were implemented].</p>	<p>"... if there was something to come out of this in terms of linking with particular GP practices. Maybe if we looked at what teams, in terms of rival care teams, were up and running - and the more established. If you wanted to do a piece of work. I could have a conversation with primary care issues around alcohol and drug misuse and how we might look at that kind of sharing (PCT worker, 880). "I would be happy to meet to look at PCTs and how we can link better and try to push the alcohol issue" (PCT worker, 896).</p> <p>[Possible alcohol new service delivery model discussed and new practice pilot sketched out earlier on in this session]</p> <p>[This involves a leap of faith given:] "I am struggling to understand what you could be asking of primary care" (PCT worker, 666).</p>
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Table 9: Overall analysis of D-analysis and RQs form

Overall Analysis of D-analysis and RQs Form					
Item	Deixis stage of D-analysis	RQ 1 “What are workers learning when they are involved in the multidisciplinary implementation of the SCP?” [Bottom-up. “Analysis of the organisation of communicative action . . . to identify evidence of work-based learning” Edwards et al., 2009:179).	RQ1 “What implications may this have for theoretical understanding?” [Top down]	RQ 2 “What forms of interpersonal and organisational practice and dynamics associated with this learning?”	Comments
11	<p>Potential for SCP to be developed as a wrap-around care package for GPs and PCTs as part of EPS [Full thread].</p> <p>See POD and D-analysis form.</p>	<p>Major practice and policy development item which is achievable but regrettably does not embrace HSE addiction services at this juncture.</p> <p>Attempt to engage GPs with a new model when previous attempts have not been successful.</p> <p>Management of risk by sharing burden with GPs.</p> <p>Germ idea of rehabilitation as a social movement (CL1/502).</p>	<p>Attempt to traverse major multidisciplinary lacuna with promise of resource supports.</p> <p>Big cultural shift in working with clinicians out of mutual self and client interest.</p> <p>GP are medical model sole traders and have practical and time considerations as their priorities.</p>	<p>Role of GP as a privateer or agent of the state?</p> <p>PCT very much aligned to HSE policy.</p> <p>GPs don't attend meetings.</p> <p>“Workers don't have the mental state to think about new practice” [due to work pressures]. Current PCT re-configuration means system is very fluid.</p>	<p>GPs don't like dealing with advocates. Mutual interests, division of labour and power are central issues.</p> <p>Money and time are the key GP factors.</p> <p>PCT model struggling to deliver.</p> <p>This case example (Appendix 1) proved to be a high level schematic for explaining SCP concept and selling the system.</p>

5.6 Discussion

In conclusion this chapter has depicted only part of a wealth of data generated from the CL sessions into a format which answers the research questions and the aims of the overall study. A comparison between section 1.3 and Tables 3 and 4 in chapter 1 with Table 14 reflects a high degree of congruency between the author's perceptions of reality prior to the fieldwork with the issues raised in the CL sessions. Some issues such as practice recording, case management and NDRIC roll-out did not seem to be important in the CL sessions.

Tables 7-9 provide examples of how item 11 in Table 14 in Appendix 2 were constructed. The theoretical column of Table 9 was used to match and pinpoint items to theoretical points in the main body of the thesis. However, it could not be used to exemplify the complexity of the processes involved. This would require much descriptive analysis which might fall into the trap of conjecture.

The POD form (Table 7) provided mirror data and operational direction for the participants. The POD form, D-Analysis form and Overall analysis of D-Analysis and RQs form provided direction and evidence for the researcher to analyse the fieldwork. The POD form when presented as mirror data allowed for participants to object if they did not agree with the issues identified or the emphasis placed upon them.

From an operational perspective the process was successful in that it productively engaged the participants to address relevant issues and contradictions within their sphere of operation. This approach to data analysis systematically builds upon practice development and lays a multidisciplinary and organisational framework in which to progress work with activity systems. The SCP GP example in Appendix 1 and the commitment of the local PCT team to commence an associated pilot project is a much needed development to address policy and practice needs. The possibility of forming a collaborative arrangement with local alcohol services, to address identified cross addiction to alcohol problems, is another tangible result which promotes productive multidisciplinary activity, learning and training.

The methodology proved to be appropriate for purpose although great efforts were required, at short notice, to manage, record, analyse, produce mirror data and structure the whole recording process in terms of the academic exercise. Whilst there will always be opportunities for constructing new forms of data analysis, mirror data presentation and the depiction of results they will have to be delivered in an empirically appropriate way. If the data collection and analysis approach adopted in this study is to be utilised in the planned national roll-out of EPS it will require further development to marry practice developments to a new form of 'real time' multidisciplinary working in order to be practically relevant to the participants. Similarly future efforts to record methodological and theoretical developments will require additional forms of data analysis and will have to be doable.

Finally, the acid test is whether the results answered the research questions. It can be said that in this study the process of learning, in order to develop new practice, was faithfully depicted with the assistance of the literature review and theory

chapters. The significant efforts of the participants should be recognised regarding multidisciplinary practice development and operational achievements. It is to be hoped that the insights produced by this study will be developed further by the HSE.

Chapter 6 Discussion

6.1 Introduction

This chapter will comment on the overall research endeavour. It will connect the theoretical and practice insights identified in previous chapters and comment on their implications for the study, for practice, for theory and for further research. Significant factors in the research will be discussed. The chapter will conclude with an acknowledgement of the limitations of the study and its potential as part of the preparation for the roll-out of EPS and its contribution to work of this type.

6.2 Summary

This applied doctoral research is part of a wider project to introduce an electronic health record, embracing shared care planning and integrated care pathways, into Irish addiction services. This work has implications for the management of chronic diseases and the impetus to reconfigure primary care services into primary care teams to alleviate the burden on secondary health service providers. Across all of these mentioned initiatives there are common features, such as the lack of effective multidisciplinary working and power differential issues between workers, across social inclusion, health and personal social services. This has been characterised as fragmented, demarcated, silo working, with worker allegiances to different models of care and self interest. Importantly, there are essential differences in the addictions domain regarding worker knowledge and skills which compound the aforementioned issues and militate against effective construction of long-term client care trajectories. Policy imperatives to address such matters have been identified but they require practice solutions to address the complex area of addiction. The addiction domain has been illustrated from a policy and practice perspective. Analysis of clinical and non-clinical processes have revealed different perceptions of the nature of drug misuse as a form of treatment and practice intervention which are often based on belief systems as opposed to rational client-centred multidisciplinary practice. Differences in knowledge bases and skill levels were also identified and related to a Bernsteinian institutional analysis. The use of a pluralist theoretical lens has contributed to an analysis which addresses the deficiencies in individual theories and allows for a more considered view of the generated data. DWR was used as an interventionist methodology to tackle identified tensions and contradictions on the ground, together with a consideration of the proposed SCP tool, to develop a cogent contribution to this field of study and lay the foundation for rolling out a national electronic health record.

Overall the design of the study was appropriate and it proved to be effective in engaging the participants to address identified policy and practice problems which formed part of their daily work activities. The participants built on their previous proactive work in this area by way of distributed expertise, knowledge trails and an embryonic co-configuration approach. Attempts by the researcher to link practice with theory was tolerated well as long as it was cast within their work activities as opposed to lecturing from an ivory tower. The wealth of material gathered within the

CL sessions, although only partially illustrated in the thesis, provides evidence of the group's ability to undertake a DWR approach, which is amenable to D-analysis, and capable of changes in tool use and practice, as evidenced by the GP wrap-around care example in Appendix 1.

Data collection and analysis strategies benefited from following the LIW example and indicated that this approach is suitable for wider empirical use. A lack of empirical research in this area hampered the planning and execution of the DWR sessions which relied on the researcher's experience of managing focus groups and therapeutic groups. The management of group sessions relied on good planning and a good working relationship with the participants. The researcher's in depth knowledge of the subject area, and the oftentimes unexpressed dynamics of competitive relationships within the voluntary sector, meant that uncomfortable issues could be raised within sessions. Overall there was a high degree of openness and honesty by the participants during the research process.

The results of the study were conducive to furthering the research aims and addressing the research questions. It was noted that the full expansive learning cycle was not completed. This was due to the absence of HSE clinical colleagues in the research endeavour and the fact that a paper research proforma was used as opposed to an electronic version. The lack of participants' engagement in the Google Docs exercise was disappointing and might be explained by the contrived nature of the exercise and by not using real clients.

6.3 Discussion

This section provides an overall analysis of the previous chapters in relation to the completion of the study's endeavours. The study is a major piece of applied research for Irish addiction services in that it meets policy needs to translate integrated services aims into a practical reality. The current economic crisis lays a further requirement to restructure existing services and to tackle existing silo working. The shared care plan module within the EPS electronic health record is an essential tool in enabling such a process. Existing efforts to address national policy by way of partnership working and the adoption of case management strategies have been found wanting and there is a requirement for a new generation of thinking and working that a DWR approach can facilitate. The case for such an approach has been made and it has been translated into an empirical reality which can be further developed and replicated within the proposed electronic domain.

Chapter 2 considered the background literature by appreciating the diversity of knowledge and perspectives pertinent to the management of addiction within various paradigms. Tables 3 and 4 provided the author's assessment of the current system and the potential for change. It is interesting to compare the data in chapter 5 against this template to assess the degree to which the issues were matched and addressed. Certainly the wealth of material produced in the data analysis, much of which was not identified in the study, will prove invaluable for further work in this area. For example the material concerning continuity of care between prisons and

the community will be used to further work streams addressing Action 43 of the National Drugs Strategy.

Whilst a social constructionism approach was used to consider health and illness issues efforts were made to ensure that the realities of health as a condition were firmly adhered to and by so doing efforts to bridge the clinical/non-clinical gap were made. A review of the medicalisation thesis was undertaken in view of the aforementioned polarisation between workers in addiction services. This review assisted in recognising the multidisciplinary difficulties between workers due to differences in knowledge, skills and adherence to ill considered belief systems. It also assisted in revitalising a debate which might have been relegated as no longer appropriate today. Such a consideration, by recognising the uncomfortable aspects of working life, forms the grist of the DWR approach and allows for change in practice possibilities such as those flagged by Bleakley et al. (2011).

An effort was made to consider the utility of case management given its centrality to current policy and practice. This provided a necessary focus on an unquestioned bureaucratic approach which has relied on an intuitive belief in its appropriateness rather than one sustained by evidence of its effectiveness. The central but lowly role of the client was considered from a number of perspectives to consider the potential elevation of this role despite it being subject to various models of interpretation. Arguably the role of a drug misuser client sometimes poses difficulties for workers who despite political, policy and practice rhetoric associated with a consumerism approach fail to adequately address the role of the client against a backdrop of competing self interest with other workers. These considerations surfaced in the data analysis chapter to some extent although participants required some prodding from the researcher regarding pressures to maintain self serving interests. Whilst efforts to match changes in practice to goals such as client-centred and holistic goals were not achieved progress was made in this area. The consideration of chronic illness, new public management, health consumerism and social problem paradigms make a contribution to the overall debate from a social policy and practice perspective. This would be particularly so when such insights are conducted within change laboratory sessions and as part of activity within the SCP pedagogic device.

Chapter 3 attempted to consider a pluralist theoretical approach in understanding some of the insights which may be applicable to the field of study. This approach is likely to be controversial given the subject matter employed. However, given the limitations of current bureaucratic, medical and psychosocial approaches within the drug misuse domain a fresh approach to tackle the nitty-gritty of problems and issues is justified. This approach, which borrows heavily from work in the educational sphere, appears to be transferable to the health sphere given their mutual interest in pedagogy and learning. Attempts have been made to address fundamental issues, to address some of the deficits implicit in individual theories and proffer insights from other theorists regarding potential future development. This has lead to a cross appreciation and germination of ideas in some instances. These efforts have been made to widen the reality of working within an AT approach which has a limited recognition of the world outside the experience of the participants or the institutional influences about which they may or may not be aware. In particular a Critical Realism approach seeks to appreciate multiple realities and the possibilities

for interaction between those from the scientific and social worlds. The argument for the use of activity theory, with support from the work of Bernstein, Bakhtin and Critical Realism approach, was borne out in that the significance of agency and structural issues could be addressed. In particular an appreciation of multiple views of reality from an official and everyday discourse perspective combined Bernsteinian and Bakhtinian insights in an area where belief systems and associated attitudes prevail over attempts relying on knowledge and evidence-based practice. Chapter 4 is influenced by the aforementioned chapters and is based upon the theoretical base found within AT and DWR. It proved to be a very workable approach which delivered upon the study's expectations despite some difficulties being encountered. The study addressed the research questions, aims and objectives. It did so by illuminating the process of activity within the CL sessions, which can be related to the issues in chapters 2 and 3 and it did so in terms of the threads identified in the D-analysis. Appendix 1 demonstrates a very tangible expression of one such conclusion.

The methodology facilitated an examination of such tensions and contradictions. Ordinarily such tensions are suppressed and not subject to open structured dialogue. This approach is optimistic in that it recognises a current situation which is not satisfactory or openly articulated but reveals a possibility for workers to develop effective changes and solutions for the benefit of many.

6.4 Implications

With regards to the research questions Table 14 illustrates the learning associated with the theoretical and practical understanding of the research. This appears to connect well with the literature review and the attempts at providing a framework for theoretical understanding in Chapter 3 and the examination and construction of the SCP as a multidimensional theoretical device. Such understanding provides the direct link between theoretical understandings, which can be used to assist practical understanding, for practice development in an area where role resentments are a reality. It also serves to enforce the features of the value of current individual worker role identities in that whilst there is potential for change and modification a new all encompassing generic drug worker role is not suggested. That is, there needs to be an appreciation of individual worker role value recognised in the SCP, which is appropriate for particular client need identification and the construction of an intervention, as part of a client care trajectory. This then elevates possibilities for many workers, who use a 'top of the head' approach, to be influenced by others to develop their knowledge and skills.

The DWR sessions produced possibilities for elucidating 'generative mechanisms' in terms of addiction service activities in what can be described as an 'actual realm'. It has elevated the potential of non-clinical workers in terms of their knowledge and skills to dynamically engage with clinicians who can also feel bruised by the sustained attack on substitution treatment. Therefore, the potential for more effective working exists as does cross-fertilisation with primary care team and mental health agendas. In this way persistent tensions found in Table 14 concerning confidentiality (row5) and prisoner/community continuity of care (row9) can assist in

further policy development. It is important that “outcomes or events which occur, as a consequence of underlying generative mechanisms operating in open, complex, structure systems” which may not ordinarily be formally recorded, are recognised.

The findings reflected the importance and ascendancy of the belief and value systems held by workers which appeared to override adherence to other influences promoted by official or agency policy. This is an area for concern in relation to future development as practice needs to be grounded in practice realities which can be discussed. Engeström (1992) briefly touches on beliefs, values and priorities and the importance of multiple mediation to address issues for fear of professional isolation:

"Specialization tends to narrow diagnostic vision and to foster beliefs in the superior effectiveness of treatments prescribed by one's own specialty. This effect of specialization is reflected in the contemporary treatment of most diseases." (Katz, 1984:188).

Edwards et al. (2009:57,127) recognise the importance of beliefs and values about being professional and the claims that may be made in respect of each professional. “We were keen to identify points at which the communicative action of the participants engaged with the transformation of the institution” (Edwards et al., 2009:58).

Bleakley (2008:268) also points out that “. . . Unidirectional culture change, involving building new practices for patient safety, will be difficult to establish and harder to sustain if it is enforced, offers unwelcome colonisation, or attempts to build on a values quicksand. Values and attitudinal change are foundational, where they precede and form behavioural and performance change”.

The development of the SCP GP wrap-around care package (Appendix 1) provides evidence of the collective effort to form new practice despite all workers (HSE clinicians) not being present. This may have had an impact in addressing information and confidentiality issues and potential for bridging the clinician/non-clinician fragmented working aspects. The use of a Bernsteinian appreciation of the SCP as a multi featured pedagogic device provides an almost tangible structure in which to engage practitioners in addressing the fraught issues concerning knowledge and skill level differences. This could well lead to a thinning of insulation between workers and a readiness to accept the contributions of each worker without the tendency of creating a generic worker role or not appreciating that there is a role for all workers depending upon the client need and intervention devised within the care trajectory.

6.5 Limitations of the study

The study could have benefited from another co-worker to assist the researcher in the DWR sessions which is the norm in other forms of group work interventions. The absence of HSE colleagues meant that many issues could only be identified and partially resolved as opposed to finding possibilities for fulsome solutions. The use of the electronic version as opposed to the paper proforma was not possible at this stage of the overall project but this will take place eventually. The absence of real

clients limited the possibilities for modelling real situations as opposed to constructing fictitious clients who were probably an amalgam of a number of clients. The ethical issues concerned with the involvement of real clients would have been too problematic for this research but will be necessary in the future given the passive role of clients and the rhetoric associated with their potential for involvement by workers, agencies and the state. The research reveals what can be achieved in building upon and structuring local intelligent enthusiastic effort and linking it to overall policy and knowledge development. The work could have been done much better, but it was done, and it is open to scrutiny, as all our work should be.

The absence of HSE clinicians, in CL sessions, from the local the HSE clinic and from regional management structures, imposed significant limitations to what the research hoped to achieve. This inhibited planned progression of DWR and CHAT analysis in terms of addressing changes in future practice with all relevant parties and crystallising potential multidisciplinary solutions within a zone of proximal development. Therefore, an analysis of the data only takes us so far and has some similarities to playing football with one half of a team whilst the other half of the team plays on another pitch.

Overall, from a reflexive perspective, the author was satisfied with the interconnected theoretical base of the study and processes involved, via the CLs and D analysis. In particular, the development of the POD form proved to be a particularly useful structure to progressively lay out the data on the mirror surface and as a structure for data analysis. This enabled the group to remain focused and attend to object related relational agency working. In other words the POD form enhanced the capacity of the participants to work purposefully and collaboratively together to expand the 'object of activity'. The wealth of diverse data has been depicted in Table 14 and analysed to a certain extent in terms of D analysis sequences or threads and related generally to theoretical points in the thesis. It has also depicted threads of learning. Several of these strands could be developed by further CL sessions but some appear to be limited by a lack of information which did not arise within the sessions. For example, evidence based knowledge relating to confidentiality was not considered nor were the perspectives of HSE clinicians. However, excluding an appreciation of all the data, as depicted in Table 14 would deprive the reader of the full process. The data analysis in chapter 5 correctly focuses on the research questions, aims, objectives, outcomes and outputs of the research, as defined in section 1.6, and the achievement of producing the General Practitioner Shared Care Plan in Appendix 1. In conclusion, the role of the author was primarily that of a researcher in this context, and was accepted by the participants as such, although he would have had past interactions with the participants as a prisons advisor and a HSE addictions policy maker. These roles did not raise tensions and dialogue during CL sessions included diverse and strong opinions between all participants. The author was primarily a facilitator and not an apologist or advocate for any position or policy.

6.6 Recommendations

This thesis is the first part of a major project involving the roll-out of a national electronic health system in the Irish addiction services with the potential to embrace mental health and primary care team services. The next stage of gaining acceptance for this project involves ascertaining whether EPS is fit for purpose in embracing addiction services. The insights gleaned from this research are already impacting upon this development and could well involve local agencies using a change laboratory approach to address the tensions and issues identified in such work. The publication of this thesis will serve to identify the issues involved and hopefully gain official, professional and 'everyday' support for furthering the addiction agenda by translating the policy aims identified in national drug and alcohol policy into new practice possibilities based on a higher standard of knowledge use and recognition of true client focused interventions via co-configuration working.

6.7 Conclusion

A spider will always be a spider if he continues to weave the same web.

The challenge is to co-ordinate Irish addiction services and parallel services in the mental health and primary care team domains to respond to providing a more efficient and effective service delivery which does not rely solely on the bureaucratic oversight of self serving services which are failing to respond to current client needs and the impetus for integrated services. The role of the state and its policy agents have a positive role to play in supporting the necessary change to achieve a common integrated service which is supported by the development of shared care planning and integrated care pathways which can be provided by the common use of a multidisciplinary electronic health record tool. The crux of the matter always rests with the humans and their capacity to meaningfully and constructively engage with each other in using such a tool to develop knowledge and skill rather than adopting polarised beliefs. It is hoped that this research can make a contribution towards that end.

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Appendix 1

	Status	Date objective set	Objective & timescale	How will progress be measured	Work to be done to achieve objective	Referred to	Name of worker & agency	Outcome	Comment: reasons achieved or not
GP CLIENT									
Task 1	open	1-Nov-2010	Accept referral from Dr S for keyworking and care package. 3 month review on 1 Feb 11	Completion of needs assessment and SCP. Accepted key worker role	Need assessment and SCP commenced. Keyworking vital to address inappropriate behaviours. Liase with all relevant stakeholders, probation, clinicians, cwo's. Hook them all into electronic health record	CARP	Agency 1 Keyworker	Initially very difficult to engage, took awhile to settle down, has a tendency to drift.	Cross addiction to alcohol issue and an outstanding offence.
Task 2	open	4-Nov-2010	Currently on court adjourned supervision	Continue addressing offending behaviour issues. Prepare court report for 3/1/11	liase with PO,s and solicitors and encourage her through keywork to become more assertive	EZ Probation Officer	EZ Probation Officer	still making poor choices in friendships, is still picking up charges	very immature and still presentating as affected on a regular basis. Referred to Lisa Glassett and Probation Training Project
Task 3	open	04/11/2010	Offending/ Training Module place available in Probation Project 15 Jan 11	Completion of programme and achieving individual objectives Review 3 March 11	Address relapse and risk behaviours	LT TPP case manager	LT TPP		Maintaining contact and CBT exercises
Task 4	open	6-Nov-2010	Address alcohol cross addiction by 30/1/11	Completion of assessment and brief intervention	Completion of assessment and brief intervention	Fred CARP	FG Agency 1 advised by MR Alcohol Services Belgard		
Task 5	open	06/11/2010	Urinalysis and GP court report for 3/1/11	GP court report for 3/1/11	Keyworker to brief Probation & GP on progress by 31/12/10		Dr S and EZ Probation Officer		
Each row is completed and monitored by an individual key worker, the case manager oversees the entire plan									
	future							Use the status to toggle between different states with color coding.	Use a future code for a task not already scheduled
Date	Key Progress Notes								
02/11/2010	MMT scripting every second Friday morning. Pharmacist JD at Unicare Pharmacy, JS, GP nurse is surgery link who together with above-named have access to shared care plan with patient consent. Pugh 19/11/10								

Appendix 2

Table 10: Area profile: geographic and service provision POD form

Practice and organisational development (POD) Form				
Issues	Tensions & Contradictions	Past	Current	Future
<p><u>Area Profile:</u> <u>Geographic and service provision</u> Official stats give one story and reality another (unmerge agency data). Real activity stats not seen. CL1/192 Services distribution rationale? Profile of areas not covered (e.g. Area problems) CL2/568 Geo-social map of area indicates critical areas of resource shortages and inability to meet client need compared to others CL1/251</p> <p>E.g. What community resources do Area 1 clients have compared to Area 2?</p>	<p>HSE treatment stats not indicative of need or actual service provision - other types of drugs and activity.</p> <p><u>Reflection on medical model, medicalisation and medical care trajectory</u> and the need to define patients in need of treatment.[Put in page 4 too]</p> <p>Competitiveness between voluntary service providers for sharing info, funding and allocation of clients.</p> <p>Several critical geographical areas not serviced or represented.</p> <p>Area 2 has ethnic, intercultural and major issues - not for this research to address.</p>	<p>Options were to find a local doctor for MMT or go to DTCB in city. Areas K & F held public meetings to use community centres “to treat your own people”. (515). Counselling outreach service developed. Early demand for MMT harm reduction era developed later by stealth.CL2/304. No methadone protocol – chaos. Rogue GP scripting. Subversive & IRA involvement, heavies filming clients going for treatment. Wild West scenario. Concerned parents minding physeptone supplies for 9 clients each. Resident road blocks to stop pushers. CL2/341Horse troughs ordered with medical supplies. HSE doctor/outreach scripting. Early gemeinschaft efforts.</p>	<p>“Practical work to be done to develop a proper area analysis”</p> <p>Case management of Level1 & 2 GPs required and links to be made for those GPs who don’t opt into MMT or PCT.</p> <p>Client positive progression from clinics to GP, on existing care trajectory, results in lack of continued or wrap-around client support.</p> <p>“We’ve come a long way in 14 years”.</p> <p>Loss of community [gemeinschaft] involvement. CL2/363 GPs script only or see clients briefly. “There’s more to a person’s life than that”. “Lots of GP clients doing nothing”.</p>	<p>Analysis of individual agencies and their NDTRS profiles. Devise new fit of service provision to actual client need & best practice. Reduce dependence on HSE MMT clinics. Use of EHR (web access EPS) for operational and M&E functions. Develop voluntary sector and community development model on community development model (gemeinschaft) principles. Potential to develop a ‘Tallaght model’. Plan for non-serviced areas (link to HSE & vol sector self interest?) Re-define care trajectories in terms of new practice. “Try to normalise drug problem so as to find a solution for normal not stigmatised people” L</p>

Table 11: Area profile: geographic and service provision D-analysis form

D-Analysis Form				
Deixis	Definition & Delineation	Deliberation	Departure	Development
<p>CL1/192 <u>Checking reality</u>-official stats give one perspective, worker comments suggest another.</p> <p>Most data obtained from CL1</p>	<p>CTL data unsatisfactory as split between service providers not self evident and not showing up stats (activity) for GPs, vol sector and HSE. Many valid voluntary sector activities not recorded such as work with concerned persons and family members. CL1/239 Hidden client numbers. CL2/263 Alcohol activities not represented. CL2/282 Map of D24 highlights services and needs disparities. [Relate to POD Form, sheet 1 on this subject]</p> <p>CL2/568 Issue regarding non-provision of services to new communities</p>	<p>Use of Map exercise.</p> <p>Identification of past and current practice [Relate to POD Form, sheet 1 on this subject]</p> <p>CL1/108 Defining what a Tallaght model maybe [Dual diagnosis collective training efforts have provided some effort and evidence for this]</p> <p>CL1/91 Move towards ascendancy of rehab approach away from specialised HSE clinics and move towards PCT model</p> <p>CL1/263 Services are not addressing non-opiate clients</p>	<p>What does D24 religious organisations have that existing services are not providing?</p> <p>Discussion of past and current client care trajectory is client focused [Relate to POD Form, sheet 1 on this subject]</p> <p>CL1/308 “Why things are not what they should be regarding patients”</p> <p>CL1/398 “It would be better if we all agreed about one thing. That is we want people to get better at dealing with their own lives”</p> <p>CL1/434 Summary of an orientating process as to what was and what maybe again in terms of regaining a gemeinschaft/community development approach.</p>	<p>Record voluntary sector activities more accurately [via QUADS, EPS use and SLAs]</p> <p>CL1/411 Instigate contact with and undertake analysis of local religious organisations involvement in addiction - especially regarding detoxification</p> <p>CL1/374 Develop map exercise by profiling clients better</p> <p>Focus on developing ideas and relationships with GPs [445, 478-497, 502-506]</p>

Table 12: Development of a Tallaght model D-analysis form

D-Analysis Form Development of a Tallaght model				
Deixis	Definition & Delineation	Deliberation	Departure	Development
<p>“So who is going to say we are all working in this way?” (CL6/482). [Crux of the matter regarding power and institutions. Indicative of resistance to identified change process]</p>	<p>“It’s going to be beneficial for the client, the services that want to work in a shared way, but what about accountability to see if services are working in a shared way including GPs?” (488). Lack of control over GPs by GP coordinator Existing governance structures too split (495).</p> <p>Lots of GPs breaking their contracts by not doing what they are supposed to do (510). Option of forcing compliance or marketing the SCP idea (514). Big divide between GPs and psychiatrists in addiction (603).</p> <p>GPs don’t like people spying on them [this is governance].</p> <p>Do workers know each other when they start SCP (632)?</p> <p>Problem dealing with</p>	<p>NDS, policy docs, HSE strategy, HIQA and HSE quality directorate [Policy influences and directives to influence practice].</p> <p>It’s about changing policy into practice locally via DWR (515).</p> <p>Use of SLAs to gain compliance.</p> <p>Use M&E to examine if good practice and if not address it (531).</p> <p>People work together but it is</p>	<p>“We need someone to police it” (547).</p> <p>“How do you measure that someone is not co-operating” (574). “But, it also comes down to the people using the system” (589).</p> <p>Potential here for changing the division of labour and power structure from clinicians to the care manager (668). [See SCP GP case example]</p> <p>“Opportunity for workers to educate each other” (748).</p> <p>SMART objectives make</p>	<p>Use of evangelists [workers] first to roll out the new system (590).</p> <p>We are going to have to write protocols on how M&E research is to be managed (628). Involvement in SCP by invitation (641). Use of networking. L describes role (645-652).</p> <p>SCP facilitates workers to</p>

	<p>individual worker belief systems, philosophies (723).</p> <p>Existing case management isn't always clear (694).</p>	<p>not multi-disciplinary practice (637).</p> <p>Not acceptable [individual belief systems] when it reflects individual indulgences as opposed to points of view (728). "If you are conflicting you are doomed" (738).</p> <p>This impacts upon individual workers influence on clients e.g. drug detox-one trick pony contribution.</p> <p>Key working role [case manager role in NDRIC] is critical- "They are not the lead people if they are not recognised by the others" (698).</p> <p>"Drug treatment is a simple business complicated by fools" (849).</p>	<p>things more focused. Importance of workers linking and engagement (760).</p> <p>National policy, NDRIC doc sets overall policy and practice guidelines [Not being used] "Well they are going to have to change".</p>	<p>gain continuity of care and wrap-around clinical transfer doc. (661). Section focused on change in practice, co-configuration and control of case management (653-716).</p> <p>"I presume when we do an alcohol pilot we will get to grips with the ins and outs of it" [SCP] (714).</p> <p>"I am going to blame you lot 'cos' you're the ones that who've kicked this off-so you're translating the strategy and policy into practice" (716). "It's going to cut some unacceptable practice out". "But some things will improve the way people work –it will pull them up a couple of levels, maybe" (781). "Need to pilot this further." "Boundary issues between competitive voluntary sectors need to be addressed" (814).</p> <p>"None [other vol agencies] would want to miss out [of SCP involvement]because of fear of exclusion" "Not to have a top dog agency" [In SCP approach]. [Reply] "Drug services aren't as open as that" (827).</p>
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Table 13: Attack on SCP POD form

POD FORM				
Issues	Tensions & Contradictions	Past	Current	Future
Attack on SCP [Resistance to identified change (CL6)]	Some services just aren't going to buy into SCP part and case manager role (120-124). Loss of worker/agency autonomy. Can be ignored by agencies.	Fragmented, demarcated practice with allegiance to different models of care.	Tool that can be ignored (139).	SLAs, protocol, M&E, monitoring of compliance by HSE Quality control (192). [QUADS too]
Assumption that spirit of SCP will be practiced			Agency X will be problematic due to likely SCP inputs being not reflecting good practice and "poor style of reporting" and rehab work (151-155).	[What is that spirit?]
Assumption that tool will improve practice and patient care (157).	Multidisciplinary issues, dysfunctional working relationships. Poor skill & knowledge levels of some workers.	Clients have a tendency to stay forever in same agency [client ownership issues] (166). Agency has client agreements to perpetuate this process (171). [This encourages clients' chronic dependency and is anti-progressive practice]	Problems will still exist even in SCP despite its effort to change things. Clients can become stuck with particular agencies. Client ownership can be vital to agency survival	M&E, SLA, variance tracking could be management response to this as it would allow EPS oversight of all activity in EHR. SCP tool allows for SCP&ICP movement via case manager as client either moves up or down ICP care trajectory. Client should know what is being written about them and be involved (412).
SCP tool puts pressure on voluntary agencies and HSE to engage.	SCP becomes the tool to use as a common currency (202).	History of Tallaght in progressing new practice a positive factor (223-237).	"It is not going to work if people don't become involved" (205). "It has to be electronic and I think it is generic, its specific enough, it raises the questions that people are going to be able to fill it in a second" (256).	Organise a community information session (219).

<p>Potential use of medical flag to cloak confidential medical information (302).</p> <p>SCP tool dealing with conflict.</p>	<p>To avoid Data Protection Commissioner problems. Patient advocates to be used if in disagreement with the doctor (314-352). Some individual worker belief systems dictate practice (372).</p>	<p>Link to issue about informed consent in CL1.</p>	<p>Use of patient consent in order to have worker dialogue [advocacy] with doctor. "Patients' rights", "lobbying". "Client could move to a different worker if he does not agree with the doctor" (320).</p>	<p>If info is that sensitive don't put it into SCP (311). Confidentiality problem has to be protocol driven (367). "But if we have to explain this on the ground-for acceptance" (250). Need for dialogue regarding contentious issues [eg. Detox, going from MMT to drug free lifestyle] Can SCP cope with this?</p>
<p>SCP tool access rights by others.</p> <p>"Where is the SCP tool taking us?"</p>	<p>From specialised HSE MMT clinics to rehab as a social movement [as worker X hopes] and community development model (450). "Depending on the good work of workers" (450).</p>	<p>None or too many people involved.</p>	<p>Need to stop different client dance for each worker (471).</p>	<p>Case manager selection of key workers could be based on selection of workers with client and is not worker role based as in current EPS EHR. (377-383).</p> <p>Roll out depends on working with the evangelists (590).</p>

Table 14: Overall analysis of D-analysis and RQs form

Overall Analysis of D-analysis and RQs Form					
Item	Deixis stage of D-analysis	RQ 1 “What are workers learning when they are involved in the multidisciplinary implementation of the SCP?” [Bottom-up. “Analysis of the organisation of communicative action . . . to identify evidence of work-based learning” Edwards et al., 2009:179).	RQ1 “What implications may this have for theoretical understanding?” [Top down]	RQ 2 “What forms of interpersonal and organisational practice and dynamics associated with this learning?”	Comments
1	Checking reality against official stats which give one perspective, worker perspectives give another and objective analysis another. [Full thread] See tables 5.1 & 5.2 for POD and D-analysis of this item.	Identification of tensions and contradictions: Clients’ needs not being met. Why are clients going to religious agencies and not existing services? Are current services fit for purpose, navigable and offering clients what they want? “Trying to normalise drug problem so as to find a solution for normal not stigmatised people”.	Bakhtin- official discourse influences on differential service provision. Heteroglossia is confusing and subject to worker and agency claims-making. CR has relevance in which version or claim to reality is relevant and its affect on official and unofficial discourses.	Dominance, though insular influence of medical model. Official interpretation of limited statistics impacts on strategy and planning. Potential of SCP & EPS to encompass and categorise more relevant worker activities and impact upon necessary changes to meet policy.	Competent and incompetent discourses being challenged and setting the foundation for the creation of new innovative practice and to meet agreed national policy objectives in terms of NDS, NDRIC and Farrell policy reports.
2	Use of SCP tool involving changing roles, practice and use of tool [Partial thread taken up in GP SCP wrap-around point]	Potential use of tool to address item 1 issues. Existing bureaucratic guidelines and developing initiatives involving current case management and NDRIC guidelines not being embraced. Analysis of existing care trajectory revealed as problematic.	No understanding of SCP as a potential pedagogic device. Boundaries between non-clinical workers being verbalised as flexible (weak insulation) but agency self interests very evident.	Confirmed fragmented, demarcated working with different models of care. Possibilities and components for new care trajectory emerging and GP SCP wrap-around as a germ or generative mechanism.	CLs generated 3 SCP case examples although workers failed to engage with collective Google docs homework exercise. Absence of local HSE clinicians imposes significant limitations on DWR especially in first stage of care trajectory.

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
3	Clients progress to GP stage of care trajectory welcome but it results in diminished client support. [Partial thread taken up in GP SCP wrap-around point]	Identification of a stage at the end of the care trajectory that they can influence, where client is progressing well but is left without supports. Awareness of client status (stigma, not a proper patient/consumer)	How is the voice of the client expressed and in whose interest?(Bernstein, Maton and Bakhtin)	Clients can be subject to multiple unco-ordinated services and still be unaware of what services available.	Inability to engage with first stage of care trajectory, with HSE, because communication structures incompetent.
4	Identification of hidden alcohol problem in terms of cross addiction and problem for long-term MMT clients [Partial thread taken up in CL6 with invite to HSE national alcohol advisor] See item 10 on exploration of alcohol issue in CL6.	New discovery of the prevalence and nature of alcohol at both individual and cultural levels. Need to seek and develop expertise and model to address this issue. “Is a new form of intervention required”? CL2/517 Great contrast between the behaviour of alcohol and drug clients analysed. Classification of alcohol clients into low risk but hazardous and high risk and chronic cases problematic CL5/426.	Developing awareness of conflicting societal perspectives on alcohol for individuals and local communities.	National policy amalgamating alcohol and drug misuse but practice and service delivery implications not worked out. Insular nature of alcohol services and nature of practice in Dublin a threat to SCP concept. Contrasted with rural services.	Many long-term MMT clients now cross addicted to alcohol. Stats show high levels of alcohol abuse locally and nationally. Commitment to developing a new model of learning and practice.

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
5	Confidentiality and information sharing problems [Full thread].	<p>Major problem area which relates to data protection but is based on human behaviour, dynamics and lack of agreed national or local protocols. It reflects voluntary and statutory/voluntary levels of contribution and self interests regarding resource acquisition and differences in knowledge and skill levels.</p> <p>Potential use of medical flag to identify but cloak confidential issues CL2/616.</p> <p>Issue of urinalysis raises some care and control issues CL2/750-784.</p> <p>Issues concerning ethical gate keeping functions of clinicians regarding sensitive clinical information. Non clinical workers lack of appreciation of the sensitivity of these issues.</p> <p>Efforts to find middle ground to ensure effective communication to ensure functioning of SCP and ICP and care trajectory.</p> <p>Rule bending pressures concerning official interpretation of client progress [allied to wheel of change and MI efforts].</p>	<p>This issue has similarities to an arteriogram in that it shows up all the lines of communication, blocks and reasons for non-co-operation. It brings Bernstein's features of pedagogic communication to life.</p> <p>SCP as an electronic panopticon?</p> <p>SCP as a simularitarium –which reality? Class based analysis.</p>	<p>Implications for care and control dichotomy, which exists, but was not verbalised in DWR.</p> <p>Implication for problems concerning paucity of clinical and non-clinical communication. Possibilities for association with official discourse.</p> <p>Informed consent issues.</p> <p>“I think there is a shift in emphasis from what they are using to why they are using” CL2/726.</p> <p>Information sharing “based on benefit to client” CL2/732.</p>	<p>Major problem area with current efforts to produce interagency information sharing protocols. [Binding protocols]</p> <p>Identifies demarcation issues. [“One gets the impression that recognition of tensions followed by a leap of faith, to new practice, would put a seal on this issue.”]</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
6	<p>Concern about the accuracy of SCP contributions by workers [Full thread]</p> <p>[Implication for object setting and pursuit of client care trajectory. For whose benefit?]</p>	<p>Diversity of worker goals and object motivation in terms of care trajectory and ‘multi-d working’.</p> <p>Clandestine informal communication sometimes in place.</p> <p>Differences in worker attitudes, values and philosophy.</p> <p>Identification of client work focus - but is this influenced by worker self interest.</p> <p>Some evidence of an agency “owning the client”.</p> <p>Lack of clinical knowledge does not limit some non-clinicians to comment on clinical areas (CL3/270).</p>	<p>Workers belief the process is always unfinished (Bakhtin).</p> <p>Implications for this in terms of the operation of the SCP tool/pedagogic device.</p> <p>Implications for distorting reality and claims-making.</p> <p>“People talk about EBP but it isn’t done properly” (CL3/289).</p>	<p>Protocols may encourage genericism as opposed respecting contribution of individual workers.</p> <p>Role strain and rule breaking possibilities.</p> <p>Idea of “therapeutic abandonment” if client does not comply with clinician CL3/61</p>	<p>Competition for care manager role or lead agency role could introduce tensions and conflict concerning power issues. [Potential for crisis of confidence in system and implications for governance structure and M&E]. [Need for common co-operative and collaborative approach to address diversity of views. See item 15 development of Tallaght Model.]</p>
7	Client role [Full thread].	<p>Challenge - How to enable the client voice (needs and intervention) and the status of the client as a patient/consumer (CL3/307).</p> <p>Differential worker interests/claims-making impacting upon their representation of client interests or perception of their role as client advocate.</p> <p>“Emphasis shifting to why [client] take drugs rather than the drug”.</p> <p>How do deviant aspects of client behaviour influence patient and consumer rights?</p>	<p>Voice of client (Bakhtin, Maton etc.). Impact of new management theory and consumerism theory. Client as a bona fide patient vs. client as deviant or person to sanction. Official classification of illness (ICD, chronic illness, medicalisation versus client determined and self-actualisation resolution). Labelling theory & categorisation of clients. Should client be the boss of the SCP?</p>	<p>Implications of client having overall control of SCP tool/pedagogic device? Social movement. Ethics of Care resolution. Client deviant behaviour: (CL3). Will move to another worker? Client tells you only favourable things. Essential client needs not tackled. Blind MMT prescribing. ICD classification. Being up front. Client has to self navigate system.</p>	<p>“Who is to be master that’s all” Alice in Wonderland. Client navigation problem (CL3/446) to existing services and to those unofficial ones he finds more appropriate (religious). [Rhetoric around client voice] [Can client boss the SCP pedagogic device?] [Clinician tendency towards long-term MMT rather than drug free lifestyle goal or object setting]</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
8	<p>Exploration of co-configuration and the client care trajectory and potential role of client advocate [Full thread].</p> <p>Link to item 16: “So who is going to say that we are all working in this way”? The role of power and institutions in SCP [Full thread].</p> <p>Role of the advocate deliberation.</p>	<p>Co-configuration is a feature of practice (e.g. success of D24 dual diagnosis project as a learning achievement) but CL difficulty in comprehending co-configuration as an academic observation of new practice structure despite researcher produced handouts and explanation.</p> <p>“Advocates will freak GPs out” (CL3/896). Advocates rather than key workers? (893).</p>	<p>Awareness of everyday knowledge (Bernstein and Maton) as opposed to having overview of academically constructed knowledge, models and interactions on a structure/agency basis.</p> <p>[Is addiction a chronic disease?]</p> <p>[Hybrid discourse and model but D24 is doing it naturally]</p>	<p>Problem with ‘client for life concept’ (Lloyd’s Bank advert film). Possibility for the development of a collective consciousness [The Borgs in Startrek!]. Potential for development of Tallaght model and use of SCP inside EPS.</p> <p>Role of individual worker as opposed to joint multi-d working. [Role of gate keepers].</p> <p>Workers leave the system because of frustration (CL3/961).</p> <p>How to change visions into reality (CL3/975).</p> <p>You need trust and participation and there isn’t trust (CL3/980).</p>	<p>Movement toward a bio-psychosocial model.</p> <p>Awareness of client entity: “They move in a circle, they have their own community and they know what’s out there . . . they move in groups”CL3/827 [Could be a description of a deviant subculture]</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
9	Exploration of “the black hole phenomenon” in relation to continuity of care between prisons and the community [Full thread]	<p>Prisons a lacuna in continuity of care and an unknown territory for community. It is dysfunctional organisation with no continuity of care between clinical and rehab pathways and competitiveness between agencies who comply with own outside departments. [Clinical myopia as well as clinical and institutional insularity].</p> <p>[Clients “partying” on discharge as opposed to continuity of care and maintenance of stability or drug free state].</p>	<p>Care/control dichotomy.</p> <p>Confidentiality and info sharing.</p> <p>Inappropriateness of current information and leakages.</p> <p>Official discourse reflects dominant reality with absent mechanisms to ensure continuity of care.</p> <p>Worker/agency self interests and power struggles which undermine each other and prevent co-ordination of a dysfunctional system.</p> <p>Panopticon potential of prisoner position.</p>	<p>Potential to have world overview and construct a bridge to transcend lacuna by imposing a community structure of SCP and EPS.</p> <p>“It’s never clear to me who makes the decisions”.</p> <p>“You speak a different language to us”.</p> <p>“We need a process to line up decision making and communication”.</p> <p>“There are a number of ways we can do it”. Essential requirement” Need to know client situation at a particular point in time. When we don’t know them-we need to know them” (575).</p>	<p>Possibility of continuing collaborative work to develop wrap-around rehabilitation thread around successful clinical pathway as dominant model with HSE imprimatur. Allied to Action 43 NDS and Farrell report Potential for pilots between prisons and D24.</p> <p>[Bureaucratic and army hierarchical structure of IPS.</p> <p>Prison is an interlude in care continuum (930). Multi-d working in prison is dysfunctional and demarcated (CL4/970).</p> <p>[Improved communication is the essential requirement].</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
10	<p>Exploration of alcohol issues identified in point 4 in terms of community mobilisation and new practice development [Full thread]</p> <p>Scratched the surface only on this issue – will develop a community mobilisation pilot and brief alcohol intervention service.</p>	<p>Workers admit need to acquire knowledge and advice on direction in alcohol area regarding individual and community response. Knowledge trails and distributed expertise.</p> <p>Need to consider work with families/concerned persons (CP) and how that impacts upon tradition client/worker dyad. Also, are CPs managed as separate or joint treatment entities?</p> <p>Need to consider differential between alcohol and drug treatment practice development –implications for addiction synergies, practice and policy development.</p> <p>Develop brief intervention practice and community education programmes (advice of HSE advisor) taken.</p> <p>Develop a toolkit for alcohol treatment (239).</p>	<p>Congruence with developing community development ethos.</p> <p>“I think you have hit the nub of it-trying to create a space for the abstinence model [in addiction services]” (CL6/350).</p>	<p>Need to examine rural joint service provision to learn potential new forms of service delivery and co-configuration.</p> <p>Utilise learning from previous dual diagnosis efforts. Lessons for EPS here.</p> <p>Alcohol potential developments:</p> <p>1 Education, screening, brief interventions.</p> <p>2 Higher specialised therapy, detox, tier 3&4 services. Different care plans for each type and align with PCT too.</p> <p>3 Examine rural model for city application (320, 331). See Note 2</p>	<p>Note 2: Alcohol service ethos threat to SCP in that it provides an insular service model and want to take over client completely for duration of state provided alcohol treatment. Latter has demarcation rules with drug treatment services.</p> <p>Alcohol clients better behaved than drug ones.</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
11	<p>Potential for SCP to be developed as a wrap-around care package for GPs and PCTs as part of EPS [Full thread].</p> <p>See POD and D-analysis form.</p>	<p>Major practice and policy development item which is achievable but regrettably does not embrace HSE addiction services at this juncture.</p> <p>Attempt to engage GPs with a new model when previous attempts have not been successful.</p> <p>Management of risk by sharing burden with GPs.</p> <p>Germ idea of rehabilitation as a social movement (CL1/502).</p> <p>Contribution of package to the management of risk issues for client and GP.</p> <p>Devising new networking, referral system, care trajectory and practice- especially with PCT and public health nurse (630).</p>	<p>Attempt to traverse major multidisciplinary lacuna with promise of resource supports.</p> <p>Big cultural shift in working with clinicians out of mutual self and client interest.</p> <p>GP are medical model sole traders and have practical and time considerations as their priorities.</p> <p>Generally clinicians have concern regarding their own positivistic practice areas out of inclination and resource erosion.</p> <p>Attempts to create the structure vehicle for forming new practice and structures?</p>	<p>Role of GP as a privateer or agent of the state?</p> <p>PCT very much aligned to HSE policy.</p> <p>GPs don't attend meetings.</p> <p>“Workers don't have the mental state to think about new practice” [due to work pressures]. Current PCT re-configuration means system is very fluid and reluctant to complicate matters with SCP unless convincing rewards evident.</p> <p>[Worker survival under threat let alone crystallisation of new practice and service possibilities].</p> <p>Relevance of current guidelines/protocols development in face of restructuring demands.</p>	<p>GPs don't like dealing with advocates. Mutual interests, division of labour and power are central issues.</p> <p>Money and time are the key GP factors.</p> <p>PCT model struggling to deliver.</p> <p>This case example (Appendix 1) proved to be a high level schematic for explaining SCP concept and selling the system.</p> <p>GPs want things to be practical and immediate.</p> <p>PCT manager agreeable to pilot project with selected GPs.</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
12	<p>Problemising the role of the case manager [as defined by NDRIC]. [Partial, but critical, thread]</p> <p>Link to item 16: “So who is going to say that we are all working in this way”? The role of power and institutions in SCP. [Full thread]</p> <p>Link to attack on SCP</p>	<p>Case manager role differentially defined by NDRIC and other fora. Important role in the control of the pedagogic device “Who is going to boss the system?”</p> <p>Role of SMART objectives as neutral regulatory mechanism.</p> <p>Differential acceptance by workers of referrals (including concerned persons) by agencies. Client currently not dependent on clinical acceptance of referral save for entry into methadone treatment.</p>	<p>This role impacts upon distribution of power and principles of control and social order and potential to develop pedagogic codes.</p> <p>Potential influences of this role in terms of division of labour, boundary crossing and overall monitoring of the SCP. and system management functions.</p>	<p>Major implications for multidisciplinary working in the SCP arena. Implications for new roles, division of labour and insularity considerations. Recognition of protocols, SLAs and inclination to develop own protocols (e.g. of QUADS and Ana Liffey protocols) Implications for future co-configuration and the structure of training.</p>	<p>Does this item lead to the development of a mutually recognised and adopted national model of care?</p>
13	<p>Exploration of the function of the SCP as a tool [Partial thread] (CL6).</p> <p>Link to item 16</p>	<p>“It’s just a tool that’s all it is.” “It is not going to stop current practice.” [Top of the head, worker ownership of clients, client for life and “We will do what we want”] (CL6/1139).</p> <p>[Prevents] “client becoming stuck with particular agencies” or agencies not taking responsibility for client because of fear of risk or that they will be the only service involved (CL6/166).</p>	<p>Multipurpose function of the SCP tool.</p> <p>Device to address tensions and contradictions full on.</p> <p>SMART allows for following the object. Potential for rule breaking to undermine it.</p>	<p>Potential lack of faith in people using SCP tool or of clients progressing satisfactory within it. Issues to do with confidence in skill and knowledge levels regarding worker competence to be included in system.</p> <p>“Need for vision thing” [about use of tool] (CL6/250). “Do an information session for D24 on the use of SCP” CL6/256</p>	<p>SMART objectives. Time-related, worker responsibility, replaces rafts of co-ordinators (12-22). Raising standards, governance & variance tracking (389). Who is going to overview practice in EPS? (487). No current use of a SCP type tool, no hierarchy or framework. Multiple funding sources making governance and accountability difficult (525-531). How to increase cooperation.574</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
14	<p>Problemising the clinical/non-clinical working relationships. [Critical item]</p> <p>Link to item 5 confidentiality and information sharing problems.</p>	<p>Confidentiality/information sharing/data protection issues.</p> <p>“Another way of saying **** off” “The client will tell you his details anyway” [argument for client being in charge –but what about informed consent?]</p> <p>Issue of client consent and informed consent allowing communication.</p> <p>Potential disputes about function of advocacy role.</p>	<p>Workers entrenched and well insulated in own silos</p> <p>Multidisciplinary working with others of lower or differing knowledge and skill levels raises insulation issues (Bernstein).</p> <p>Dominance of medical model and characteristics of medicalisation.</p> <p>Significance of regulatory mechanism in SCP tool.</p>	<p>Use of medical flag - as a device to flag confidential issue and referral to a clinician without disclosing matter.</p> <p>Informed consent issues problematic.</p>	<p>What justification for denying role of advocates or limiting engagement of approved others? Need to be mindful of notes and what you write. “Vol sector nosiness”.</p> <p>Protocol driven solution limited and does not allow for evolution of dialogue. Assumption by voluntary workers they are equal with clinicians.</p> <p>Management of worker competency roles.</p>
15	<p>Development of the Tallaght Model.</p> <p>[Also refer to item 16 development]</p>	<p>Recollection of past in terms of gemeinschaft features and the nature of the community development model they once practiced. Recognition of need to invoke a resurgence of a community development model.</p> <p>DWR features of dual diagnosis project augur well for SCP development in D24. DWR features of this project verbalised by researcher (distributed knowledge, knowledge trails, co-configuration etc.) to stimulate movement towards a ZPD.</p>	<p>CR recognition of different versions of realities and its reflection in policy, service provision and as knowledge to change.</p> <p>Client stigmatisation issues</p> <p>Germ cell development of an ‘Ethics of social care model’ as a potential common philosophy for all workers. Potential promotion of rehabilitation as a social movement.</p>	<p>Redefining care trajectory, recognising major rehabilitation and community development components.</p> <p>Development of an egalitarian and mutually supportive SCP and ICP based care trajectory, between clinicians and client selected voluntary sector workers, on a client focused and not worker/agency self interest basis.</p>	<p>Competitiveness features between local agencies is a major issue and although CLs were prompted regularly by the researcher concerning this issue it was not fully addressed.</p> <p>Congruency with NDS and HSE social policy and business plan evident as was developing new practice aligned with these initiatives.</p>

Item	Deixis stage of D-analysis	RQ 1 “What are workers learning . . . in the multidisciplinary implementation of the SCP?”	RQ1 “What . . . theoretical understanding?”	RQ 2 “What forms of interpersonal and organisational practice and dynamics	Comments
16	<p>“So who is going to say that we are all working in this way”? The role of power and institutions in SCP. [Full thread]</p> <p>See linking POD and D-analysis forms.</p> <p>Note links to items 6,8 &13 in Table 13</p>	<p>Accountability to whom? Governance, M&E issues. [Current multi-disciplinary working has similarities to independent states in medieval Italy.]</p> <p>Lack of effective organisational management, SLAs and no monitoring controls as in UK.</p> <p>Consideration of different worker belief systems which result in diversity of opinion and practice (723).</p>	<p>HSE, HIQA policy, compliance and strategy frameworks not yet in place. Potential for changes in division of labour and role change.</p> <p>Developing awareness of existing and different philosophies and potential paradigms to move practice forward.</p> <p>NDRIC case management system not part of discussion.</p> <p>Current client case recording poor.</p> <p>Minimal influence of other case management systems on worker practice (Homeless Agency and NDRIC).</p>	<p>“I presume when we do an actual pilot we will get to grips with it – the ins and outs” [Comment as to why Google Docs exercise not completed].</p> <p>It will take a real system and real clients to test and develop the system.</p> <p>Awareness of lack of regulatory mechanisms, especially in relation to GPs although potential for co-operation possible based on development of mutual worker interests and knowledge.</p> <p>Boundary issues within voluntary sector need to be addressed. “None would want to miss out because of fear of exclusion” (827) and fear of one agency dominating another.</p>	<p>Attack on SCP [resistance].</p> <p>Nurse prescribing instead of reliance on GPs would be a game changer (Farrell Report).</p> <p>Individuals do their own thing and have their own empires.</p> <p>It is just that it has not been properly discussed”.</p> <p>“Opportunity to educate each other” (748).</p> <p>“SMART objectives may also help” (756).</p> <p>“. . . as we are dealing with a very specific piece of work so maybe that might cut it out” (756-763). [lack of collaboration]</p> <p>[Evangelists best people to develop practice]</p>

Appendix 3

INFORMATION SHEET AND CONSENT FORM HEALTH SERVICE EXECUTIVE SHARED CARE PLANNING

CHANGE LABORATORY PROJECT

You are invited to participate in a number of group work sessions with other staff. The aim of this study is to improve the planning and use of our services for all clients and to develop new understandings of practice following the introduction of the shared care planning module in the DAIS database. You do not have to take part in this study unless you decide to and if you decide not to take part this will not affect you in any way.

The Health Service Executive Transition Framework document outlines the need to reconfigure services to provide easy access for patients within an integrated structure. This encourages effective interdisciplinary working with other agencies and workers across the health and social inclusion domains. The addition of a shared care plan (SCP) module will enable workers across the clinical and non clinical services to engage in holistic care planning in a more efficient and effective way than heretofore. This will be promoted by undertaking participatory research with developing transformative models of professional learning in order to comprehend the changing way of working using the SCP module. This research will inform practice and management issues within this sector as well as contributing to better and new knowledge and practice across the social inclusion sector. This work will address multidisciplinary practice within interagency working because it will be focusing on shared care planning, interagency practice and negotiated new forms of working which can span agency boundaries. "Co-configuration describes the dynamic networks between service users, products and providers that characterise emerging forms of interagency dialogue. Learning in and for co-configuration goes beyond conventional team-working and, instead, encourages *knotworking* as the principle of rapidly changing, partially improvised, distributed forms of collaboration".

If you do decide to participate you will be invited to attend a series of six to eight sessions to discuss your perceptions and experiences of working with the shared care plan module and to contribute to developing practice in this area. These sessions will be structured using a 'Change Laboratory' model. This is a participative and iterative process which involves using a camcorder and other information items to record and discuss the group's views. The data will be used by the group on an ongoing basis and will ultimately be subject to data analysis and be part of an anonymised thesis written by Julian Pugh. Julian will be supervised by Professor Daniels from Bath University, who will also have access to the recordings for supervision purposes only.

If you do agree to be part of this project, you can decide to leave it at any time. If you want any more information before deciding to join, or while you are in the project, you will have the right to ask.

I have been given a copy of this form and understand and agree to be part of the Shared Care Planning Change Laboratory Project.

Signed Witness Date:

----- Forwarded message -----

From: **Vicki Buckley** <vjeb20@bath.ac.uk>
Date: 6 November 2009 11:48
Subject: Feedback from SREAP (14-Oct-09 meeting)
To: julian.pugh@gmail.com
Cc: Gillian O'Carroll <G.P.O'Carroll@bath.ac.uk>

Dear Julian,

Apologies for the delay in responding to you. SREAP have now considered and approved your proposal for an additional 3-interview pilot study in preparation for the previously approved project 'An activity theory examination of the user perspective in the development of an electronic health record'. SREAP advise that the same participant information etc can be used for the pilot study as for the main study, however participants in the pilot version should be informed that they are taking part in one of three pilot interviews (either verbally or via an insert on the participant information sheet).

Kind regards,
Vicki

Dr Vicki Buckley
School Administrator
School for Health
University of Bath
Claverton Down
Bath, BA2 7AY

Tel: 01225 383368
Fax: 01225 383833
Email: V.J.E.Buckley@bath.ac.uk

Appendix 4

Structured Interview Schedule

(Notes in italic and in parenthesis are to assist the interviewer)

Purpose of interview:

“Please read and sign information sheet if you have not already done so. Do you understand the process or want to ask any questions?”

These questions concern care planning within your organisation.

These questions concern your views about intra and interprofessional learning.

These questions ask about change and multidisciplinary activity at work.

Your responses will be analysed and maybe used as contributions to the Change Laboratory meeting that we will be holding. If I intend to use your answers in these meetings I will inform you prior to the meetings seeking your permission to use them”.

.....

QUESTIONS:

1 These questions concern your individual work and how this relates to others

(What ideas are revealed in their actions and what contradictions are revealed in their actions, in their organisations as they do their work)?

Briefly describe the primary purpose of your role.

What is the rationale for the post (theoretical, practice and social policy)?

What are the objects of activity in your drug related work and how do these relate to those of other workers.

(“Objects are not to be confused with goals. The object is the constantly reproduced purpose of a collective activity system that motivates and defines the horizon of possible goals and actions (Leont'ev, 1978; Engeström et al., 1995; Daniels, 2007:523)

What are the objects of your work activity? What is being worked on?

(What do you actually do and how do you further these objects.

Use “So What? Approach to each reply to drill down”.)

What motives do you have in pursuing these activities and how are they translated into actions.

How are these translated into operations which form part of your work routine?

*(Focus on what practitioners **do** as they work on tasks.)*

What needs to be worked on (*articulate the object*) that is not being worked on?

How do external influences on you as a worker (from others) become internalised by you and how are they reformulated into decisions and actions which are then externalised by you in your work activities?

2 These questions concern your membership of your agency and team.

What is the structure of the current addiction team?
What role do you have in multidisciplinary (md) working within the agency?
What is the history of md working in the agency?
How has the agency developed interagency working?
What is current md working in the agency like?
What is positive about it? Why?
What is negative about it? Why?
What is being worked on in relation to md working (the objects?)
How does the former relate to the local business plan, if at all?
How should the future of MD working be like?

What is its relationship with team members in terms of interprofessional:
- working
- functioning
- and learning
(personal and interprofessional)

2 These questions concern your membership of the Tallaght network of drug treatment and rehabilitation agencies.

What is the structure of the current addiction network?
What role do you have in md working within the network?
What is the history of md working in the network?
How has the agency developed interagency networking?
What is current md working in the network like?
What is positive about it? Why?
What is negative about it? Why?
What is being worked on in relation to md working (the objects?)
How does the former relate to local task force or partnership business plans, if at all?
How should the future of MD working across the network be like?

What is its relationship with team members in terms of interprofessional:
- working
- functioning
- and learning
(personal and interprofessional)

3 These questions are in relation to community interagency relationships:

How does learning take place?
What model is this based on?

Is this based on the clinical model? If not what model?

What form does care planning take?

To what extent is it separate or integrated . . . in terms of individual worker functioning and inter-professional communication?

What are the predisposing knowledge bases of team members?
and what are their impacts vis-a-vis each other.

How is knowledge acquired?

What models of practice (addiction and general) do you prefer?

What beliefs, values and vision do you hold in relation to practice?

How do your views compare with others you work with?

How do you see your role?

How do you see your role in relation to other workers in the network?

Do you have any concerns about your role?

How would you see your role developing?

What is your position (issues) on confidentiality and information sharing?

Do you have any challenges about this?

How are your relations with other workers in the network?

Are there any issues about information sharing or referrals?

Are there any boundary issues between workers in the network?

Do these issues related to resources, gate-keeping, tensions, differences?

How are the differences (contradictions) between the people you work with addressed?

How would you describe them? (*What, how, why and where*)

Do you have any information or documentation on current and past agency practice and any efforts to improve or change practice?

What external influences impact upon practice?

How is change effected, and by whom, and on what basis?

What is the relevance of the local business plan and policy (HSE) in relation to practice, policy and learning in this area?

What opportunities do you have for learning and changing practice and how is this achieved?

How is this process encouraged or discouraged?

How does this differ between other workers?

What existed before current system of inter-professional working in terms of treatment and care planning for clients and how did this effect day-to-day working?

What exists currently in terms of inter-professional working in terms of treatment and care planning for clients and how does this effect day-to-day working? What is being worked on (*the objects*)?

Think about a typical current case:

Describe that case

What are the positive aspects about care planning?

What would you change to make the process better?

Are current interactions between you and your colleagues sufficient?

What would you change to make the process better?

Do you have a vision of what an ideal team/inter-professional working/inter-agency would be like?

How would you get this change to happen?

END INTERVIEW

Many thanks for your assistance. I will use your answers to prepare for the group sessions that we will be undertaking. I will not be identifying any of your answers but if I want to I will ask your permission.

Guidance taken from Kaptelinin et al. (1999).